KLRD

Ashley Stites
Fiscal Analyst
785-296-3181
Ashley.Stites@klrd.ks.gov

Health and Social Services

F-1 Family First Prevention Services Act

Background and History

The federal Family First Prevention Services Act (FFPSA), included in the Bipartisan Budget Act of 2018 (HR 1892), was signed into law on February 9, 2018. FFPSA enables states to use funds under Title IV-E and Title IV-B of the Social Security Act (designated in this article as SSA) to provide enhanced support to children at risk of entering foster care. The bill authorizes federal reimbursement of mental health and substance abuse prevention and treatment services, in-home parent skills-based programs, and kinship navigator services. The bill also includes new restrictions on federal reimbursement for children placed in non-foster home placements.

Prior to the enactment of FFPSA, the Title IV-E foster care maintenance payments program provided federal reimbursement to states for payments made to provide shelter, food, and clothing for children in foster care. The funding also covered administrative costs, training of child welfare staff and foster parents, recruitment of foster parents, and data collection.[1] States, territories, and tribes with an approved Title IV-E plan have the option to use these funds for prevention services for children at risk of entering foster care.

Title IV-B provides funding for services to ensure children at risk of entering foster care can safely stay at home. The funding can be used for child protective services, caseworker activities, counseling, emergency assistance, family preservation services, time-limited family reunification services, and family support or prevention services.[2] FFPSA eliminates the time limit for family reunification services, requires states to implement electronic interstate processing systems for children in foster care, and reauthorizes Regional Partnership Grants.

Part I – Prevention Activities Under Title IV-E

Eligibility

States that choose to provide Title IV-E prevention services must submit a Prevention Services and Programs five-year plan as part of the state's Title IV-E plan (SSA Section 471(3)(5)). The plan must describe the target population for the services, specific outcomes

for children and families, the state's evaluation strategy, the specific practices the state plans to use, the state's plan for implementation, the state's consultation with other agencies that serve children and families, steps taken to support and enhance child welfare caseworkers, the state's plan to oversee caseload size, and an assurance that the state will report to the U.S. Department of Health and Human Services (HHS).

The Kansas Department for Children and Families (DCF) intends to submit a Prevention Services and Programs five-year plan as part of its Title IV-E plan due on June 30, 2019. DCF is waiting on additional guidance from HHS.

States may use Title IV-E to provide prevention services to a child who is a "candidate for foster care," defined as a child at imminent risk of entering foster care but who can remain safely in the child's home as long as services or programs are provided or a child whose adoption or guardianship arrangement is at risk of disruption or dissolution (SSA Section 475(13)), a child in foster care who is pregnant or parenting foster youth (SSA Section 471(e)(2)(B)), or parents or kin caregivers (Section 471(e)(1) of the SSA).

Services available for federal reimbursement under Title IV-E include in-home parent skills-based programs (such as parent skills training, parent education, and individual and family counseling) and mental health and substance abuse prevention and treatment services provided by a qualified clinician. These services are limited to 12 months, beginning on the date the child or family is identified in a prevention plan as eligible for services under Section 471(e)(1)(A) and (B) of the SSA.

State Requirements

States must maintain a written prevention plan that identifies the prevention strategy, lists all services or programs that will be provided to or on behalf of the child, and complies with any other requirements HHS establishes. Additionally, in the case of a youth in foster care who is pregnant or parenting a child in foster care while in state custody, the prevention plan must be included in the child's case plan and include the prevention strategy for any child born to the youth (SSA Section 471(e)(4)(A)).

Services and programs provided to or on behalf of the child must be trauma informed. Trauma-informed services are provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions (SSA Section 471(e)(4)(B)).

Any service provided must meet the following general practice requirements:

- The practice has a book, manual, or other available writings that specify the components of the practice protocol and describe how to administer the practice;
- There is no empirical basis suggesting, compared to its likely benefits, the practice constitutes a risk of harm to those receiving it;
- If multiple outcome studies have been conducted, the overall weight of evidence supports the benefits of the practice;
- Outcome measures are reliable and valid, and are administrated consistently and accurately across all those receiving the practice; and
- There is no case data suggesting a risk of harm that was probably caused by the treatment and that was severe or frequent.

In addition to the general practice requirements, the services must be provided in accordance with promising, supported, or well-supported practice requirements (SSA Section 471(e)(4)(C)). States may not receive a federal reimbursement unless the state plan includes a well-designed and rigorous evaluation strategy. HHS may waive this requirement if the evidence of the practice is compelling and the state meets continuous quality improvement requirements for the practice (SSA Section 471(e)(5)(iii)(II)). HHS is anticipated to issue guidance regarding specific

practice criteria and pre-approved services and programs by October 1, 2018.

States are required to collect and report information for each child for whom, or on whose behalf, mental health and substance abuse prevention and treatment services or in-home parent skills-based programs are provided. This information must include the specific services or programs provided, the duration of services, and the child's placement status at the beginning and the end of the one-year period for any child determined to be a candidate for foster care and whether the child entered foster care within two years after being determined a candidate for foster care.

DCF is currently identifying evidence-based practices in Kansas the agency may be able to develop to meet the requirements of FFPSA. These programs include Healthy Families, Parent Management Training–Oregon Model, Trust-Based Relational Intervention, and Health in Pregnancy. The agency is also considering other home visitation programs.

Federal Payments

Prevention services will be reimbursable at 50.0 percent from federal fiscal year (FFY) 2020 to FFY 2026. This includes allowable administrative costs necessary for the proper and efficient administration of the state plan and training costs for personnel employed or preparing for employment by the state agency or local agency administering the plan. Beginning FFY 2027, prevention services are reimbursable at the applicable Federal Medical Assistance Percentages (FMAP) rate. Additionally, at least 50.0 percent of the amount paid to the state in any fiscal year must be for prevention services that meet the well-supported practice criteria.

Maintenance of effort is required for foster care expenditures. States electing to provide Title IV-E prevention services and programs must maintain the same level of state foster care prevention expenditures each fiscal year as the expenditure amount for FFY 2014. States must report state foster care expenditures for each fiscal year the state participates in the Title IV-E prevention program. State foster care prevention expenditures include Temporary Assistance for Needy Families (TANF), Title IV-B, Social Services Block Grant (SSBG), and any other state or local agency funds used for prevention services and activities (SSA Section 471(e)(7)).

Payments for Children with Parents in a Licensed Residential Treatment Facility

A child who is placed with a parent who is in a licensed residential treatment facility for substance abuse is eligible for Title IV-E payments if the recommendation for the placement is specified in the child's case plan before the placement, the treatment facility provides parenting skills training, parent education and individual and family counseling, and the facility has a trauma-informed treatment model (SSA Section 472(j)).

DCF is working to identify a substance abuse treatment program to provide the services required under FFPSA. The agency is in the process of developing referral policies and procedures.

Payments for Evidence-Based Kinship Navigator Programs

Approved kinship navigator programs are eligible for Title IV-E payments if the program is operated in accordance with promising, supported, or well-supported practices and meet the criteria for the practices (SSA Section 471(e)(4)(C)).

Annual Updates and Assistance

Beginning FFY 2021, HHS must annually publish the percentage of candidates for foster care who did not enter foster care, the total amount of expenditures made for mental health and substance abuse prevention and treatment services or in-home parent skills-based programs, and data regarding prevention services measures. Prevention services measures will be published annually for each state. HHS must submit periodic reports on the provision of prevention services and programs to Congress and make the reports available to

the public. FFPSA provides an appropriation of $1.0 million per year, beginning FFY 2018, for the clearinghouse, data collection, and evaluations under Section 476(d) of the SSA.

Other Changes

Changes to Title IV-B

Title IV-B of the SSA promotes state flexibility in the development and expansion of a coordinated child and family services program that ensures all children are raised in safe, loving families by protecting and promoting the welfare of all children; preventing neglect, abuse, and exploitation of children; supporting at-risk families; promoting safety, permanence, and the well-being of children in foster care and adoptive families; and providing training, professional development, and support to ensure a well-qualified child welfare workforce (SSA Section 421). FFPSA makes the following changes to Title IV-B funding:

- Eliminates the time limit for family reunification services while in foster care and permitting time-limited family reunification services when a child returns home from foster care (SSA Section 431(a)(7));
- Requires states to implement an electronic interstate case processing system for children in foster care, guardianship, or adoption by 2026 (SSA Section 471(a)(25));
- Provides $5.0 million in grants for FFY 2018 for states to develop the electronic interstate case processing system (SSA Section 437(b)); and
- Reauthorizes regional partnership grants that work to alleviate substance abuse and support parents for five years. These grants can be used on a statewide basis and can be awarded to both non-profit and state programs (SSA Section 437(f)).

DCF is currently partnering with the University of Kansas to provide Kansas Serves Substance Affected Families (KSSAF), a five-year project funded through a regional partnership grant. KSSAF serves families with children ages zero to three who are in out-of-home placements due to reasons associated with parental substance abuse. The project began in 2014 and will continue through 2019.

Reviewing and Improving Licensing Standards for Placement in a Relative Foster Family Home

HHS is expected to identify reputable model licensing standards for foster family homes (as defined in Section 472(c) of the SSA) by October 1, 2018. States must report by April 1, 2019, whether state licensing standards are in accordance with model standards identified by the Secretary of HHS, and, if not, the reason for the specific deviation and a description as to why the national model standard is not appropriate for the state. Additionally, states must report whether the state has elected to waive standards established in Section 471(a)(10)(A) of the SSA for relative foster family homes and describe which standards the state waives. If the state elects to waive the standards, the state must explain how caseworkers are trained to use the waiver authority, whether the state has developed a process or provided tools to assist caseworkers in waiving non-safety standards to quickly place children with relatives, and a description of the steps the state is taking to improve caseworker training on the process. If the state is not electing to waive the standards, the state must report the reason why (SSA Section 471(a)).

Development of a Statewide Plan to Prevent Child Abuse and Neglect Fatalities

States must report on steps taken to track and prevent child maltreatment death. The state will submit a description of the steps the state is taking to compile complete and accurate information on the child deaths as required by federal law. This includes gathering relevant information on the deaths from organizations in the state (such as state vital statistics, child death review teams, law enforcement agencies, and offices of medical examiners), and describing the steps

the state is taking to develop and implement a comprehensive statewide plan to prevent the fatalities (SSA Section 422(b)).

Ensuring the Necessity of Placement That Is Not a Foster Family Home

FFPSA limits foster care maintenance payments to two weeks for placements that are not foster homes or qualified residential treatment programs (QRTP). Additionally, the state will only receive payments on behalf of a child in a placement other than a foster home or QRTP if the child is placed in a child-care institution or a licensed residential family-based treatment facility. Child-care institutions include QRTPs; a setting specializing in providing prenatal, postpartum, or parenting supports for youth; a supervised setting in which the child is living independently (for children 18 years and older); and a setting providing high-quality residential care and supportive services to youth who have been found to be, or are at risk of becoming, sex-trafficking victims.

Under FFPSA, the term "foster family home" means the home of any individual or family that is licensed or approved by the state where the foster child resides, adheres to the reasonable and prudent parenting standard, provides 24-hour substitute care for the child, and provides care for no more than 6 foster children (with some exceptions for parenting youth, siblings, meaningful relationships with a family, and special training) (SSA Section 472(c)).

QRTPs must have a trauma-informed treatment model, registered or licensed nursing staff on-site to the extent the program's treatment model requires, facilitate outreach to family members, document family integration into the treatment process, and provide discharge planning and family-based care support for six months after discharge (SSA Section 472(k)(4)). A trained professional or licensed clinician must complete an assessment for each child placed in a qualified residential treatment center to determine if the placement is appropriate. The assessment must determine the strengths and needs of the child using age-appropriate evidence-based validated functional assessment tools approved by HHS. The state will only receive federal payments on behalf of the child in a qualified residential treatment facility if the assessment is completed within 30 days. Additionally, if the assessment determines the placement in the QRTP is no longer appropriate, the child returns home, or the child is placed in a foster home or adoptive placement, federal payments will only be made on behalf of the child during the period necessary to transition the child home or to the new placement. The state will not receive any federal payment after 30 days of the determination that the placement in the QRTP is no longer appropriate.

As of June 30, 2018, 620 youths are currently placed in a congregate care setting, including psychiatric residential treatment facilities. Many of these facilities have indicated to DCF they can meet the QRTP standards by October 1, 2019.

Continuing Support for Child and Family Services

Several federal grants are available for child welfare programs under FFPSA. An appropriation of $8.0 million is available through FFY 2022 for competitive grants to support the recruitment and retention of high-quality foster family homes. FFPSA also reauthorizes the Stephanie Tubbs Jones Child Welfare Services Program, the Promoting Safe and Stable Families Program, the Court Improvement Program, and the John H. Chaffee Foster Care Independence Program through FFY 2021.

1 NCSL. (2018, May 15). Family First Prevention Services Act (FFPSA). Retrieved from http://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx

2 NCSL. (2017, May 17). Child Welfare Financing 101. Retrieved from http://www.ncsl.org/research/human-services/child-welfare-financing-101.aspx

For more information, please contact:

Ashley Stites, Fiscal Analyst
Ashley.Stites@klrd.ks.gov

Erica Haas, Principal Research Analyst
Erica.Haas@klrd.ks.gov

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

KLRD

Robert Gallimore
Principal Research Analyst
785-296-3181
Robert.Gallimore@klrd.ks.gov

Health and Social Services

F-2 Foster Care

Foster care services are provided when the court finds a child to be in need of care pursuant to the Revised Kansas Code for the Care of Children (KSA 2018 Supp. 38-2201 to 38-2283). Child in Need of Care (CINC) proceedings can be divided into two categories: those concerning children who lack adequate parental care or control, or have been abused or abandoned; and those concerning children who commit certain offenses listed in KSA 2018 Supp. 38-2202(d)(6)-(10). This article focuses on the first group.

Foster care services in Kansas were privatized in 1997 due in part to long standing concerns about the quality of services for children in state custody, in addition to a 1989 class action lawsuit alleging the Department of Social and Rehabilitation Services (SRS), now known as the Department for Children and Families (DCF), failed to care adequately for children who may have been victims of abuse or neglect. The court approved a settlement in 1993 containing 153 requirements with which SRS was required to comply within certain time frames. SRS did not achieve compliance with many of the settlement requirements for handling cases, and in early 1996, SRS officials informed the Legislature they were moving toward privatization to improve the quality and efficiency of services. After what contractors conceded was a chaotic transition, SRS was found to have successfully completed its settlement terms in 2002.

Currently, DCF contracts with two service providers in four regions for foster care placements, adoptions, and family preservation services: Saint Francis Community Services, which provides service to the West and Wichita regions, and KVC Health Systems, Inc., which provides service to the East and Kansas City regions. The service providers subcontract with other providers. Several other agencies throughout the state are involved with foster care, such as the Kansas Children's Service League and the Children's Alliance of Kansas. These agencies and others provide a variety of services, including information and resources for current and prospective foster parents.

The current contracts run through the end of FY 2019 (June 30, 2019). New child welfare grants and contracts will take effect on July 1, 2019. As of September 2018, proposals for these new grants and contracts were being presented, with selection of providers being scheduled to take place by December 2018.

While the details of the new grants and contracts will not be finalized and known until the selection and negotiation process is complete, when announcing its request for proposals for the new grants and contracts in May 2018, DCF outlined a variety of desired changes from the current contracts, including:

- Increasing foster care catchment areas from four to eight, making each area smaller;
- DCF contracting directly with child placing agencies (CPAs);
- Implementing new caseload size limits for case managers; and
- Requiring every provider use a single, unified statewide placement management system.

Preliminary Issues for CINC Proceedings

CINC proceedings typically begin with a report to DCF, which may be made by anyone who suspects a child may be in need of care.

Additionally, the following are required to report any suspicion of abuse or neglect:

- Persons providing medical care or treatment;
- Persons licensed by the State to provide mental health services;
- Teachers and other employees of educational institutions;
- Licensed child care providers;
- Firefighters, emergency medical services personnel, and law enforcement officers;
- Juvenile intake and assessment workers, court services officers, and community corrections officers;
- Case managers and mediators appointed to help resolve any contested issue of child custody, residency, visitation, parenting time, division of property, or other issue; and
- Persons employed by or working for an organization that provides social services to pregnant teenagers.

Reports can be made to local law enforcement when DCF is not open for business. Once a report is received, KSA 2018 Supp. 38-2226 requires DCF and law enforcement to investigate the validity of the claim and determine whether action is required to protect the child. When a report indicates there is serious physical harm to, serious deterioration of, or sexual abuse of the child and action may be required to protect the child, DCF and law enforcement conduct a joint investigation. If there are reasonable grounds to believe abuse or neglect exist, DCF must take immediate steps to protect the health and welfare of the child, as well as that of other children under the same care.

KSA 2018 Supp. 38-2231 requires law enforcement to place a child in protective custody when an officer reasonably believes the child will be harmed if not immediately removed from the situation where the child was found or the child is a missing person. A court may not remove a child from parental custody unless it finds there is probable cause to believe: the child is likely to be harmed if not immediately removed from the home; allowing the child to remain in the home is contrary to the welfare of the child; or immediate placement is in the child's best interests. The court also must find there is probable cause to believe reasonable efforts have been made to maintain the family unit and prevent the unnecessary removal of the child from the child's home, or an emergency exists that threatens the child's safety.

To issue an *ex parte*[1] order for protective custody, the court also must find there is probable cause to believe the child is in need of care. An *ex parte* order must be served on the child's parents and any other person having legal custody of the child. Along with the order, the court may enter an order restraining any alleged perpetrator of physical, sexual, mental, or emotional abuse from residing in the child's home; visiting, contacting, harassing, or intimidating the child, another family member, or witness; or attempting to visit, contact, harass, or intimidate the child, another family member, or witness. A restraining order must be served on the alleged perpetrator.

The court may place the child in the protective custody of a parent or other person having custody of the child; another person, who is not required to be licensed under the Kansas law governing child care facilities; a youth residential facility; a shelter facility; or, under certain circumstances, the Secretary for Children and Families (Secretary). Once issued, an *ex parte* order typically will remain in effect until the temporary custody hearing.

When a court evaluates what custody, visitation, or residency arrangements are in the best interests of a child no longer residing with a parent, KSA 2018 Supp. 38-2286 requires substantial consideration of a grandparent who requests custody, which must be included in the record. The court must consider the wishes of the parents, child, and grandparent; the extent to which the grandparent has cared for the child; the intent and circumstances under which the child is placed with the grandparent; and the physical and mental health of all involved individuals. If the court places the child in the custody of the Secretary for placement (rather than a grandparent), the law requires substantial consideration of a grandparent who requests placement in the evaluation for placement. If the grandparent is not selected, the Secretary must prepare and maintain a written report with specific reasons for the finding.

Court Proceedings

CINC Petition

If DCF determines it is not otherwise possible to provide services necessary to protect the interests of the child, it must recommend that the county or district attorney file a CINC petition. Pursuant to KSA 2018 Supp. 38-2233, the county or district attorney will then review the facts, recommendations, and any other evidence available and determine whether the circumstances warrant filing a petition. If warranted, KSA 2018 Supp. 38-2214 provides the county or district attorney prepares and files the petition, the contents of which are outlined in KSA 2018 Supp. 38-2234, and appears and presents evidence at all subsequent proceedings. KSA 2018 Supp. 38-2233 also allows an individual to file a CINC petition and be represented by the individual's own attorney in the presentation of the case.

Once filed, if the child is in protective custody, KSA 2018 Supp. 38-2235 allows the court to serve a copy of the petition on all parties and interested parties in attendance at the temporary custody hearing or issue summons to all those persons if not present. Otherwise, KSA 2018 Supp. 38-2236 instructs the court to serve the guardian *ad litem*[2] (GAL) appointed to the child, custodial parents, persons with whom the child is residing, and any other person designated by the county or district attorney with a summons and a copy of the petition, scheduling a hearing within 30 days of when the petition was filed. Grandparents are sent a copy of the petition by first class mail.

Interested Parties and Attendance at Court Proceedings

In addition to receiving notice of hearings, KSA 2018 Supp. 38-2241 gives parties and interested parties the right to present oral or written evidence and argument, call and cross-examine witnesses, and be represented by an attorney. Grandparents are interested parties in CINC proceedings and have participatory rights, subject to the court's restriction on participation if it is in the child's best interests. Other interested parties may include persons with whom the child has resided or shares close emotional ties and other persons as the court allows based on the child's best interests.

KSA 2018 Supp. 38-2247 allows anyone to attend CINC proceedings leading up to and including adjudication, unless the court determines closed proceedings or the exclusion of an individual would be in the child's best interests or is necessary to protect the parents' privacy rights. Dispositional proceedings for a child determined to be in need of care, however, may be attended only by the GAL, interested parties and their attorneys, officers of the court, a court-appointed special advocate, the custodian, and any other person the parties agree to or the court orders to admit. Likewise, the court may exclude a person

if it determines it would be in the best interests of the child or the conduct of the proceedings.

Temporary Custody Hearing

KSA 2018 Supp. 38-2243 governs temporary custody hearings, which must be held within three business days of a child being placed in protective custody. Notice of the hearing must be provided to all parties and nonparties at least 24 hours prior to the hearing. After the hearing, the court may enter a temporary custody order if there is probable cause to believe the child is a danger to self or others, is not likely to be available within the jurisdiction of the court for future proceedings, or the child's health or welfare may be endangered without further care. The court may modify this order during the pendency of the proceedings to best serve the child's welfare and can enter a restraining order against an alleged perpetrator of physical, sexual, mental, or emotional abuse. The court may place the child with a parent or other person having custody of the child; another person who is not required to be licensed under the Kansas law governing child care facilities; a youth residential facility; a shelter facility; or, under certain circumstances, the Secretary.

Order of Informal Supervision

At any time after the petition is filed and prior to an adjudication, a court can enter an order for continuance and informal supervision pursuant to KSA 2018 Supp. 38-2244, placing conditions on the parties and entering restraining orders as needed. The order can continue for up to six months and may be extended for an additional six months. If the child is not placed with a parent, the court must give substantial consideration to a grandparent who requests custody, as discussed above.

Adjudication and Disposition

KSA 2018 Supp. 38-2251 requires the court to enter a final adjudication or dismissal of a CINC petition within 60 days of the filing of the petition, unless good cause for a continuance is shown on the record. KSA 2018 Supp. 38-2250 specifies the petitioner must prove by clear and convincing evidence the child is in need of care. Otherwise, KSA 2018 Supp. 38-2251 requires the court to dismiss the proceedings. If the child is found to be in need of care, however, pursuant to KSA 2018 Supp. 38-2253, the court will receive and consider information concerning the child's safety and well-being and enter orders concerning custody and a case plan, which governs the responsibilities and time lines necessary to achieve permanency for the child.

Prior to entering an order of disposition, KSA 2018 Supp. 38-2255 requires the court to consider the child's physical, mental, and emotional condition and need for assistance; the manner in which the parent participated in the abuse, neglect, or abandonment of the child; any relevant information from the intake and assessment process; and evidence received at disposition concerning the child's safety and well-being. Based on these factors, the court may place the child with a parent; a relative of the child; another person who is not required to be licensed under the Kansas law governing child care facilities; any other suitable person; a shelter facility; a youth residential facility; or, under certain circumstances, the Secretary. This placement will continue until further order of the court. Along with the dispositional order, the court may grant reasonable visitation rights upon finding visitation would be in the child's best interests or may enter a restraining order against an alleged perpetrator of physical, sexual, mental, or emotional abuse.

Permanency

If the child is placed with a parent, KSA 2018 Supp. 38-2255 allows the court to impose terms and conditions to assure the proper care and protection of the child, including supervision of the child and parent, participation in available programs, and any special treatment the child requires. If permanency is achieved with one parent without terminating the other's parental rights, the court may enter child custody orders, including residency and parenting time, determined to be in the child's best interests and must complete a parenting plan pursuant to KSA 2018 Supp. 23-3213.

If the child is not placed with a parent, a permanency plan must be developed and submitted to the court within 30 days of the dispositional order by the person with custody of the child or a court services officer, ideally in consultation with the child's parents. KSA 2018 Supp. 38-2263 outlines the required contents of the plan, including descriptions of the child's needs and services to be provided in addition to whether the child can be "reintegrated," *i.e.,* reunited with a parent or parents. If there is disagreement among the persons necessary to the success of the plan, a hearing will be held to consider the merits of the plan.

KSA 2018 Supp. 38-2255 lists the relevant factors in determining whether reintegration is a viable alternative, including, among others, whether the parent has committed certain crimes, previously been found unfit, and worked towards reintegration. If reintegration is not a viable alternative, within 30 days, proceedings will be initiated to terminate parental rights, place the child for adoption, or appoint a permanent custodian. A hearing on the termination of parental rights or appointment of a permanent custodian will be held within 90 days. An exception exists when the parents voluntarily relinquish parental rights or consent to the appointment of a permanent custodian.

KSA 2018 Supp. 38-2269 allows courts to terminate parental rights if it finds by clear and convincing evidence the parent is unfit by reason of conduct or condition that renders the parent unable to care properly for a child and the conduct or condition is unlikely to change in the foreseeable future. Further, it lists factors the court can consider to determine parental unfitness and provides a parent may be found unfit if the court finds the parent has abandoned the child; custody of the child was surrendered or the child was left under such circumstances that the identity of the parents is unknown and cannot be determined, in spite of diligent searching; and the parents have not come forward to claim the child within three months after the child is found.

Finally, KSA 2018 Supp. 38-2271 outlines circumstances that create a presumption of unfitness, including a previous finding of unfitness; two or more occasions in which a child in the parent's custody has been adjudicated a child in need of care; failure to comply with a reasonable reintegration plan; and conviction of certain crimes. Parents bear the burden of rebutting these presumptions by a preponderance of the evidence. When the court finds a parent is unfit, it can authorize an adoption if parental rights were terminated, appoint a permanent custodian, or continue permanency planning. Preference for placement is given to relatives and persons with whom the child has close emotional ties.

A permanency plan may be amended at any time upon agreement of the plan participants. If the permanency goal changes, however, a permanency hearing will be held within 30 days, as outlined in KSA 2018 Supp. 38-2264 and 2018 Supp. 38-2265. Even without a change in the permanency goal, KSA 2018 Supp. 38-2264 requires a permanency hearing be held within 12 months after a child is removed from the home and at least annually thereafter. If parental rights are terminated or relinquished, the requirements for permanency hearings will continue until the child is adopted or a permanent custodian is appointed. When permanency has been achieved with either a parent or nonparent to the satisfaction of the court, the court will close the case.

Fiscal Year 2018 Statewide Foster Care Statistics

An average of 351 children were removed from the home and placed into foster care each month, with a total number of 4,212 children placed during fiscal year (FY) 2018. An average of 317 children exited foster care placement outside of their home each month, with a total of 3,805 children exiting during FY 2018. In 70 percent of cases, the primary reason for removal was abuse or neglect. A majority of children in out-of-home settings were placed in family foster homes, and the most common permanency goal was reunification. The total average out-of-home placement length of stay was 19.1 months, with reunification as the leading reason for ending placement. Further information on statistics, as well as current figures and regional data, can

be found at http://www.dcf.ks.gov/services/PPS/Pages/FosterCareDemographicReports.aspx.

Recent Legislation and Reform Efforts

In addition to many existing workgroups, task forces, and committees that consider possible reforms to the CINC process and the delivery of foster care services, standing and special legislative committees also have considered changes in recent years. Most recently, the 2017 Legislature established the Child Welfare System Task Force. More details regarding these efforts follow.

Legislation

Beginning in 2011, the Legislature made changes to the law to expand the rights of grandparents, designating them as interested parties (2011 House Sub. for SB 23) and requiring substantial consideration of grandparents who request custody when a child is removed from parental custody (2012 SB 262).

In 2014, a foster parents' bill of rights, Sub. for SB 394, was introduced, considered, and ultimately referred to the Judicial Council and to the Special Committee on Judiciary for interim study. The Special Committee recommended introduction of a bill proposed by the Judicial Council and that additional consideration be given to the grievance process. That bill was introduced in 2015 as SB 37, which was heard by the Senate Judiciary Committee; however, the Committee did not take action on the bill.

In 2016, the House and Senate Judiciary Committees discussed variations on legislation introduced in 2015 concerning use of a power of attorney to delegate care and custody of a child to another, which had been referred to the Judicial Council for further study. The 2016 Legislature ultimately passed SB 418, the Host Families Act, which allows a child placement agency or charitable organization to provide temporary care of children by placing a child with a host family. Host families are subject to screening and background checks and do not receive payment other than reimbursement for actual expenses. The Act also allows DCF to provide information about respite care, voluntary guardianship, and support services, including organizations operating programs under the Act, to families experiencing financial distress, unemployment, homelessness, or other crises and to parents or custodians during a child protective investigation that does not result in an out-of-home placement due to abuse of a child.

Placement must be voluntary and shall not be considered an out-of-home placement, supersede any court order, or preclude any investigation of suspected abuse or neglect. A parent may place a child by executing a power of attorney that delegates to a host family any powers regarding the care and custody of the child, except power to consent to marriage or adoption, performance or inducement of an abortion, or termination of parental rights. The power of attorney may not be executed without the consent of all individuals with legal custody of the child, and execution is not evidence of abandonment, abuse, or neglect.

The power of attorney may not exceed one year but may be renewed for one additional year. The bill includes an exception, however, for parents serving in the military, who may delegate powers for a period longer than one year if on active duty service, but no more than the term of active duty service plus 30 days. A parent executing a power of attorney under the Act can revoke or withdraw the power of attorney at any time. Upon such withdrawal or revocation, the child must be returned to the parent as soon as reasonably possible.

Additionally, 2016 SB 418 specified nothing in the CINC Code compels a parent to medicate a child if the parent is acting in accordance with a physician's medical advice, and in these circumstances, absent a specific showing of a causal relation between the actions and harm to the child, a parent's actions do not constitute a basis for determination that a child is a CINC, removal of custody of a child, or termination of parental rights. Further, the bill allowed county or district attorneys from another jurisdiction to access the official file and social file in a CINC proceeding when involved with a pending

CINC case involving any of the same parties or interested parties.

Special Committee on Foster Care Adequacy

The Legislative Coordinating Council created a Special Committee on Foster Care Adequacy in 2015 and again in 2016 to study DCF oversight of foster care contractors; whether a working group would aid in addressing foster care concerns; and the selection, qualification, and responsibilities of foster parents. The 2015 Special Committee recommended evidence-based, peer-reviewed research on family structure be given high priority when considering best interests and making foster care placement decisions. Additionally, it recommended introduction of legislation creating a joint committee to oversee foster care or alternatively, that a Senate committee and a House committee be charged with reviewing the topic of foster care.

The 2016 Special Committee studied similar issues and considered a two-part report of DCF released by the Legislative Division of Post Audit (LPA). The 2016 Special Committee identified a number of concerns and recommended:

- Reintroduction of a bill establishing a foster care oversight task force;
- Expanded use of citizen review boards in CINC cases;
- Affirmation of the right of biological parents and grandparents to visitation;
- The Legislature address the LPA findings on foster care and adoption and concerns raised by the audit;
- DCF investigate the value of additional vendors for foster care programs;
- DCF report annually to Senate and House standing committees; and
- The LPA committee consider addressing concerns regarding the low response rate to LPA's survey of public employees and contractor employees.

LPA Report on Foster Care and Adoption

Parts 1, 2, and 3 of the report, entitled "Foster Care and Adoption in Kansas: Reviewing Various Issues Related to the State's Foster Care and Adoption System," are available on LPA's website. Search "foster care" at http://www.kslpa.org/search/ to find the report.

Part 1 identified concerns and made recommendations related to ongoing efforts to improve child protective services; failure to consistently perform background checks for foster parents and to conduct monthly in-person visits; and foster homes with insufficient sleeping space and insufficient financial resources.

Part 2 looked at compliance with state and federal law and found DCF had not followed some of the safety and living condition requirements reviewed in Part 1. Further, it found DCF had materially complied with most, but not all, federal requirements in 2014 and 2015 and had exceeded half of the federal outcome requirements in FY 2016 but did not meet others. Finally, it found DCF must implement a program improvement plan to address issues identified by a 2015 federal review.

Part 3 examined whether the Kansas foster care system has had sufficient capacity to provide necessary foster care services, finding issues with staffing shortages, large caseloads, and low morale among caseworkers. Children in foster care received most of the physical and mental health services they needed, with exceptions. Many counties and cities did not appear to have enough licensed foster homes, although there were sufficient open beds statewide. DCF could be more proactive in monitoring and collecting management information about the foster care system, but has recently begun to expand its use of data in overseeing the foster care system. LPA identified several instances in which children were placed in foster homes that did not comply with licensing standards, but noted that DCF is making significant changes to the inspection process.

Part 3 also looked at Kansas' performance on federal outcomes for children and families over

time, finding no significant change from 2000 to 2013 and noting the significant limitations of these outcome measures, including for comparison between states.

Finally, Part 3 compared the cost of the State directly providing foster care and adoption services with maintaining the current privatized system, estimating such transition would incur up to $8 million more in ongoing costs and significant start-up costs. LPA also noted the other significant factors that would have to be considered in making such a transition.

Child Welfare System Task Force

The 2017 Legislature passed House Sub. for SB 126, which directed the Secretary for Children and Families to establish a Child Welfare System Task Force to study the child welfare system in the State of Kansas. The bill specified various entities and stakeholders to be represented on the Task Force (including six legislators) and directed the Task Force to convene working groups to study the following topics: the general administration of child welfare by DCF; protective services; family preservation; reintegration; foster care; and permanency placement. Additionally, the Task Force and each working group were directed to study the following topics:

- The level of oversight and supervision by DCF over each entity that contracts with DCF to provide reintegration, foster care, and adoption services;
- The duties, responsibilities, and contributions of state agencies, nongovernmental entities, and service providers that provide child welfare services in the State of Kansas;
- The level of access to child welfare services, including, but not limited to, health and mental health services and community-based services, in the State of Kansas;
- The increasing number of children in the child welfare system and contributing factors;
- The licensing standards for case managers working in the child welfare system; and
- Any other topic the Child Welfare System Task Force or working group deems necessary or appropriate.

The appointments of Task Force members were completed in July 2017, and the Task Force began meeting in August 2017. Working group appointments were completed in September 2017 and began meeting in October 2018.

In accordance with SB 126 requirements, the Task Force submitted a preliminary progress report to the 2018 Legislature. The Task Force and Working Groups continued meeting in 2018, with the Working Groups submitting their reports and recommendations to the Task Force in August and September 2018.

SB 126 requires the Task Force to submit a final report to the Legislature by January 14, 2019. The final report must include, but is not limited to:

- Recommended improvements regarding the safety and well-being of children in the Kansas child welfare system;
- Recommended changes to law, rules and regulations, and child welfare system processes; and
- Whether an ongoing task force or similar advisory or oversight entity could aid in addressing child welfare concerns and any other topics the Task Force deems appropriate.

1 *Ex parte* orders are orders issued involving one party, usually for temporary or emergency relief.
2 For more information on the role of the GAL, see KSA 2018 Supp. 38-2205.

For more information, please contact:

Robert Gallimore Principal Research Analyst
Robert.Gallimore@klrd.ks.gov

Iraida Orr, Principal Research Analyst
Iraida.Orr@klrd.ks.gov

Ashley Stites, Fiscal Analyst
Ashley.Stites@klrd.ks.gov

Amy Deckard, Assistant Director for Information Management
Amy.Deckard@klrd.ks.gov

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

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KLRD

Whitney Howard
Principal Research Analyst
785-296-3181
Whitney.Howard@klrd.ks.gov

Health and Social Services

F-3 Medicaid Waivers

This article provides information related to the history of Medicaid waivers in the United States, Medicaid waivers specific to Kansas, and the history of waiver integration proposals.

The History of Medicaid

Medicaid is a partnership between the federal government and the states with shared authority and financing, created by Congress in 1965 (Title XIX of the Social Security Act). The program was designed to finance health care services for low-income children, their parents, the elderly, and people with disabilities. Medicaid has become the nation's largest source of funding to provide health services to low-income people.

State participation in Medicaid is optional. However, the federal government's financial share of Medicaid financing creates an incentive for the states. To date, no state has declined to participate. All 50 states, the District of Columbia, American Samoa, the Commonwealth of the Northern Mariana Islands, Guam, Puerto Rico, and the U.S. Virgin Islands participate and administer their own Medicaid plans. Although all states participate, eligibility varies widely because the states can choose to cover additional people and services above and beyond the federal minimum requirements.

Medicaid Expansion

Provisions of the federal Patient Protection and Affordable Care Act (referred to throughout this article as ACA) expanded Medicaid to all Americans under age 65 whose family income is at or below 138 percent of the federal poverty level (FPL) by January 1, 2014. (*Note:* This amount has been cited as 133 percent FPL. However, because of modified adjusted gross income calculations, this threshold is effectively 138 percent FPL). Under the provisions of the ACA, if a state did not expand Medicaid, the state risked losing its entire federal Medicaid allotment.

The Medicaid expansion provision led to challenges in the U.S. Supreme Court. On June 28, 2012, the Supreme Court ruled in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519,132 S. Ct. 2566, 183 L. Ed. 2d 450 (2012), that Congress may not make a state's entire existing Medicaid funding

contingent upon the state's compliance with the ACA provision regarding Medicaid expansion. Consequently, Medicaid expansion is voluntary and has become a highly discussed topic in state legislatures across the country.

As of November 7, 2018, 36 states and the District of Columbia have expanded Medicaid, and 14 states have not participated in expansion.

KanCare: Medicaid in Kansas

Kansas participates in Medicaid, but it has not expanded the program under the ACA. In 2017, legislative action was taken to expand Medicaid through HB 2044. The bill passed the Legislature, but was vetoed by the Governor. The House of Representatives sustained the Governor's veto.

Kansas administers Medicaid through the program known as KanCare, which was launched in January 2013 and currently serves more than 415,000 Kansans. Some of the services provided under KanCare include doctor's office visits and hospital care, behavioral health services, dental and vision care, medicine, non-emergency medical transportation, nursing facility services, weight-loss surgery, and contractor specific value-added services.

The Kansas Department of Health and Environment (KDHE) and the Kansas Department for Aging and Disability Services (KDADS) administer the KanCare program.

KDHE maintains financial management and contract oversight as the single state Medicaid agency, while KDADS administers the Medicaid waiver programs for disability services, mental health, and substance abuse and operates the state hospitals and institutions. Additionally, Kansas contracts with three managed care organizations (MCOs) to coordinate health care for nearly all Medicaid beneficiaries. In June 2018, KDHE awarded contracts to Sunflower State Health Plan, United Healthcare, and Aetna Better Health of Kansas, Inc., to serve as the state's MCOs. These new contracts are set to begin January 1, 2019, and end December 31, 2023.

Each Medicaid consumer is enrolled with one of the KanCare health plans. Consumers have the option during open enrollment once a year to change to a different KanCare health plan if they wish to do so.

KDHE submitted a request to extend the KanCare program under a Section 1115 waiver to the Centers for Medicare and Medicaid Services (CMS). CMS approved a one-year extension of the current KanCare demonstration, which was set to expire on December 31, 2018. The State submitted an application to renew KanCare through 2023. The application was approved by CMS on December 18, 2018.

Types of Medicaid Waivers Approved by CMS

Sections 1115 and 1915(b) and (c) of the Social Security Act give the U.S. Secretary of Health and Human Services (HHS) authority to waive provisions of the law to encourage states to test new or existing ways to deliver and pay for health care services in Medicaid and the Children's Health Insurance Program (CHIP). A state must apply for and receive approval from CMS in order to operate a waiver.

Section 1115 Research & Demonstration Projects

Section 1115 of the Social Security Act gives the Secretary of HHS authority to approve experimental, pilot, or demonstration projects. These demonstrations can give states additional flexibility to design and improve their Medicaid programs. The purpose of these demonstrations is to demonstrate and evaluate state-specific policy approaches to better serve Medicaid populations. See the CMS website for more information: *https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html*.

CMS performs a case-by-case review of each state's Medicaid proposal. CMS has invited states to propose reforms that promote Medicaid's objectives, such as reforms that would:

- Improve access to high-quality, person-centered services that produce positive health outcomes for individuals;
- Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term;
- Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals;
- Strengthen beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision making;
- Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition; and
- Advance innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid.

In general, Section 1115 waivers are approved for an initial five-year period and can be extended for an additional three to five years. Demonstrations must be "budget neutral" to the federal government, which means during the course of the project, federal Medicaid expenditures cannot be more than federal spending without the waiver.

Currently, there are 27 states that have approved Section 1115 waivers. Those states are Alabama, Arkansas, California, Colorado, Delaware, Florida, Illinois, Indiana, Iowa, Louisiana, Michigan, Minnesota, Mississippi, Missouri, Montana, New Hampshire, New York, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Virginia, Washington, West Virginia, and Wyoming. Additionally, several states have Section 1115 waivers that are listed as "pending" approval with CMS. According to a search of the CMS website on September 14, 2018, KanCare is listed by CMS as pending approval, although the KanCare demonstration was extended until December 31, 2018. See *https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html* to search for the current status of states' waiver authority.

In January 2018, CMS posted new guidance for state Section 1115 waiver proposals to condition Medicaid on meeting work requirements. Arkansas, Indiana, and New Hampshire have approved Section 1115 Medicaid waivers containing work requirements. Section 1115 waivers with work requirements are pending in Alabama, Arizona, Kansas, Maine, Michigan, Mississippi, Ohio, South Dakota, Utah, and Wisconsin. In June 2018, the District of Columbia federal district court invalidated the Secretary of HHS's approval of Kentucky's Section 1115 waiver containing work requirements (*Stewart v. Azar*, 313 F. Supp. 3d 237, 245 (D.D.C. 2018)).

Section 1915(b) Managed Care Waivers

Section 1915(b) waivers are one of several options available to states that allow the use of managed care in the Medicaid program. Under the 1915(b) waiver, states have the following four options:

- 1915(b)(1): restricts Medicaid enrollees from receiving services within the managed care network (freedom of choice);
- 1915(b)(2): utilizes a "central broker" (enrollment broker);
- 1915(b)(3): uses cost savings to provide additional services to beneficiaries (non-Medicaid services waiver); and
- 1915(b)(4): restricts the provider from whom the Medicaid eligible may obtain services (selective contracting waiver).

Thus, the 1915(b) waivers allow the state to provide Medicaid services through managed care delivery systems, effectively limiting the consumer's choice of providers. CMS has started the process of "modularizing" its current 1915(b) waiver application to separate the various statutory authorities. See *https://www.medicaid.gov/medicaid/managed-care/authorities/index.html* for more information.

Currently, there are 35 states that have approved Section 1915(b) waivers with CMS. Those states are Alabama, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New York, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, and Wyoming.

Section 1915(c) Home and Community Based Services Waivers

The Medicaid Home and Community Based Services (HCBS) Waiver program is authorized under Section 1915(c) of the Social Security Act. Through the HCBS Waiver, states can assist Medicaid beneficiaries by providing a wide range of services that permit individuals to live in their homes or communities and avoid institutionalization. Programs can provide a combination of standard medical services and non-medical services. Standard medical services include, but are not limited to, case management, home health aides, personal care, adult day health services, and respite care. States can propose other services that may assist in diverting or transitioning individuals from institutional settings to their homes or communities.

Currently, 47 states and the District of Columbia have 1915(c) waivers approved with CMS. The only states that currently do not have an approved 1915(c) waiver with CMS are Arizona, Rhode Island, and Vermont.

Section 1332 State Innovation Waivers

Section 1332 of the ACA permits a state to apply for a State Innovation Waiver (Section 1332 waiver, now also referred to as a State Relief and Empowerment Waiver). Guidance was issued in 2015 related to these new waivers, and waivers were available beginning January 1, 2017. According to the National Conference of State Legislatures, at least 35 states have considered legislation to begin the Section 1332 waiver application process as of late October 2018. However, on October 22, 2018, CMS, HHS, and the Department of the Treasury published new guidance intended to "expand state flexibility, empowering states to address problems with their individual insurance markets and increase coverage options for their residents, while at the same time encouraging states to adopt innovative strategies to reduce future overall health care spending." The comment period for the rule ends December 24, 2018. For more information, see *http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx* and *https://www.federalregister.gov/documents/2018/10/24/2018-23182/state-relief-and-empowerment-waivers*.

Medicaid Waivers in Kansas

Current Medicaid Waivers

KanCare allows the state to provide all HCBS through managed care. Currently, Kansas operates seven separate 1915(c) waivers alongside a Section 1115 waiver. The seven 1915(c) waivers are Autism (AU), Frail Elderly (FE), Intellectual and Developmental Disabilities (I/DD), Physical Disabilities (PD), Serious Emotional Disturbance (SED), Technology Assisted (TA), and Traumatic Brain Injury (TBI).

To participate in a 1915(c) waiver, the individual requiring services must be financially and functionally eligible for Medicaid. Individuals with income above $747 a month must share in the cost of care, called the "client obligation." The client obligation is paid to a medical provider, not to the State of Kansas or to a KanCare MCO. Additional information for each of the seven 1915(c) waivers follows.

Autism

The Autism (AU) Waiver provides services to children from the time of diagnosis of Autism Spectrum Disorder, Asperger syndrome, or pervasive developmental disorder not otherwise specified until the child's sixth birthday. Autism services are limited to three years; however, an

additional year may be submitted for approval. To qualify for an additional year of service, the child must meet eligibility based on the level of care assessment at the annual review on the third year of services, and data collected by the MCO must demonstrate a need for continued AU Waiver services.

To apply for the AU Waiver, a parent or guardian must complete an application. The application requests basic information about the child and the child's family. Also, the application requires the parent or guardian to indicate the screening tool used in the child's diagnosis and documentation of an autism diagnosis or a signature of a licensed medical doctor or psychologist.

The Autism Program manager pre-screens for the autism diagnosis and places the child on the proposed recipient list. As of August 31, 2018, there were 263 children on the proposed recipient list. Once a position becomes available, the Program manager contacts the family to offer them the potential position. As of September 14, 2018, there were 48 children eligible to receive services under this waiver.

Kansas received direction from CMS to move consultative clinical and therapeutic services, intensive individual supports, and interpersonal communication therapy from the AU Waiver to the Medicaid State Plan Amendment. The three services that will continue to be part of the Autism Waiver are respite care, family adjustment counseling, and parent support and training. The Autism Waiver amendments were approved by CMS in June 2017.

Frail Elderly

The Frail Elderly (FE) Waiver provides home and community-based services to Kansas seniors as an alternative to nursing facility care. The waiver serves those individuals 65 and older who choose HCBS and are functionally eligible for nursing facility care. If applying for the FE Waiver, the individual should contact their local Aging and Disability Resource Center (ADRC). There are 11 ADRCs in the state. Services and supports included under the FE Waiver are adult day care, assistive technology, personal care services, comprehensive support, financial management services, home telehealth, medication reminder, nursing evaluation visit, oral health services, personal emergency response, enhanced care services (previously referred to as sleep cycle support), and wellness monitoring.

As of September 14, 2018, there were 4,628 individuals eligible to receive services without the Money Follows the Person (MFP) program and 16 individuals eligible under the MFP program. The MFP program is a federal demonstration grant given to help individuals currently living in institutional settings to choose to transition into community-based services. Individuals must qualify for Medicaid and also qualify for either the FE, PD, I/DD, or TBI waivers to participate in the program.

According to KDADS, MFP federal grant funding is coming to an end, and KDADS' last transition from the federally funded MFP occurred in July 2017. Individuals transitioning by July 2017 then have 365 days of MFP. After this period, individuals will be transitioned to the appropriate HCBS program.

Intellectual and Developmental Disability

The Intellectual and Development Disability (I/DD) Waiver provides services to individuals five years of age and older who meet the definition of intellectual disability, have a developmental disability, or are eligible for care in an intermediate care facility for individuals with intellectual disabilities. Those with a developmental disability may be eligible if their disability was present before age 22 and they have a substantial limitation in three areas of life functioning.

The point of entry into the I/DD Waiver is an individual's local community developmental disability organization (CDDO). The Program manager provides final approval of program eligibility. As of September 14, 2018, there were 3,761 individuals on the I/DD waiting list.

Services and supports under the I/DD Waiver can include assistive services, adult day supports,

financial management services, medical alert rental, overnight respite, personal care services, residential supports, enhanced care services, specialized medical care, supported employment, supportive home care, and wellness monitoring. As of September 14, 2018, there were 9,097 individuals eligible to receive services without the MFP program and 1 individual eligible under the MFP program.

Physically Disabled

The Physically Disabled (PD) Waiver provides services to individuals who are at least 16 years of age and no older than 65 years. The individual must be determined disabled by the Social Security Administration, need assistance to perform activities of daily living, and meet the Medicaid nursing facility threshold.

The point of entry for the PD Waiver is an individual's local ADRC. The Program manager provides final approval of program eligibility. As of September 14, 2018, there were 1,657 individuals on the PD waiting list. The following services and supports can be provided under the PD Waiver: assistive services, financial management services, home-delivered meals, medication reminder services, personal emergency response systems and installation, personal care services, and enhanced care services. As of September 14, 2018, 5,877 individuals were eligible to receive services without the MFP program and 25 individuals were eligible under the MFP program.

Serious Emotional Disturbance

The Serious Emotional Disturbance (SED) Waiver provides services to individuals ages 4 to 18 who have been diagnosed with a mental health condition that substantially disrupts the individual's ability to function socially, academically, emotionally, or all. The waiver is designed to divert the individual from psychiatric hospitalization to intensive home and community-based supportive services.

Services and supports under this waiver include attendant care, independent living and skills building, short-term respite care, parent support and training, professional resource family care, and wraparound facilitation. As of September 14, 2018, there were 3,437 individuals eligible to receive services under this waiver.

Technology Assisted

The Technology Assisted (TA) Waiver provides services to people through the age of 21 who require substantial and ongoing daily care comparable to the care provided in a hospital.

The individual is determined TA program eligible if he or she is 0 through 21 years of age, is chronically ill or medically fragile, requires one or more of the identified primary medical technologies and meets the minimum technology score for the specified age group, and meets the minimum nursing acuity level of care threshold for the specified age group. The point of contact for the program is the Children's Resource Connection.

Services and supports under this waiver can include financial management services, health maintenance monitoring, intermittent intensive medical care, specialized medical care, medical respite, personal care services, and home modification. As of September 14, 2018, there were 532 individuals eligible to receive services under this waiver.

Traumatic Brain Injury

The Traumatic Brain Injury (TBI) Waiver provides services to individuals ages 16 to 65 who have sustained a traumatic brain injury and would otherwise require institutionalization in a TBI rehabilitation facility. The TBI Waiver is a short-term rehabilitative program.

To be eligible for the TBI waiver, the individual must provide medical documentation to support the TBI, meet the criteria for TBI rehabilitation hospital placement, be determined disabled or have a pending determination by the Social Security Administration, and have active rehabilitation needs. If a TBI is obtained prior to

the age of 21, the individual may be considered developmentally disabled and will be referred to the CDDO prior to a TBI screening.

The point of entry for an individual is their local ADRC. Services and supports under this waiver may include assistive services; financial management services; home-delivered meals; medication reminder services; personal emergency response system and installation; personal care services; rehabilitation therapies, including behavior therapy, cognitive rehabilitation, physical therapy, speech-language therapy, and occupational therapy; enhanced care services; and transitional living skills. As of September 14, 2018, there were 398 individuals eligible to receive services without the MFP program and 1 individual eligible under the MFP program.

Waiver Integration

In the summer of 2015, KDHE and KDADS announced a plan to fully integrate the seven 1915(c) waivers into the 1115 waiver. Under this waiver integration plan, entrance to HCBS would remain the same, but services would fall into two broader categories: children's services and adults' services. The new integrated waiver would be called KanCare Community Care. KDHE and KDADS planned for this waiver integration to begin on January 1, 2017, if approved by CMS.

KDHE and KDADS held public information sessions and stakeholder work groups regarding the planned integration and continued forward with the proposal. However, the House Committee on Health and Human Services (House Committee) appointed a subcommittee to study the issue during the 2016 Legislative Session. The subcommittee issued a report proposing a bill to be considered by the House Committee requiring legislative approval of waiver integration and prohibiting implementation of waiver integration prior to January 1, 2018. The subcommittee also recommended KDHE report on the status of waiver integration planning to the Legislature in January 2017 and March 2017.

HB 2682 (2016) was introduced by the House Committee. The bill would have prohibited any state agency from making any changes to waiver services without express legislative authorization. The bill was heard by the House Committee, but died in that Committee. However, in the 2016 omnibus appropriations bill (House Sub. for SB 249), language was added directing no expenditures could be made during FY 2016 and FY 2017 to proceed with waiver integration if the proposed integration was planned to occur prior to FY 2019.

In 2017, a HCBS integration proviso was added to the omnibus appropriations bill, Senate Sub. for HB 2002. The proviso would have prohibited the integration, consolidation, or otherwise altering the structure of HCBS waivers, or submitting a proposal to combine, reassign, or otherwise alter the designated responsibilities to provide intake, assessment, or referral services for medical services, behavioral health services, transportation, nursing facilities, other long-term care, or HCBS waivers prior to FY 2020. This proviso was line-item vetoed by the Governor. In his veto message, the Governor stated concern over the broad nature of the proviso language and its potential to limit changes to non-HCBS programs within KDADS. The veto message also stated the Brownback administration would not integrate or consolidate HCBS waivers, nor make any substantive changes to the intake, assessment, and referral system for the I/DD Waiver without meaningful engagement with stakeholders and approval of the Legislature.

For more information, please contact:

Whitney Howard, Principal Research Analyst
Whitney.Howard@klrd.ks.gov

David Fye, Principal Fiscal Analyst
David.Fye@klrd.ks.gov

Iraida Orr, Principal Research Analyst
Iraida.Orr@klrd.ks.gov

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

KLRD

Erica Haas
Principal Research Analyst
785-296-3181
Erica.Haas@klrd.ks.gov

Health and Social Services

F-4 The Opioid Crisis

Background, Definitions, and Statistics

According to the Centers for Disease Control and Prevention (CDC), between 1999 and 2016, more than 630,000 people died from a drug overdose in the United States. Just over 63,000 overdose deaths occurred in 2016, with the CDC reporting that in 2016 more than 99 people died every day from an opioid-related overdose. While some deaths involve more than one drug, more than 43,000 of these deaths can be attributed to opioids, with 19,413 related to synthetic opioids, 17,087 related to prescription opioids, and more than 15,000 related to heroin.

In 2017, approximately 17.4 percent of the U.S. population filled an opioid prescription. In 2015, almost 2.0 million people suffered from prescription opioid abuse disorders, and nearly 600,000 suffered from a heroin use disorder, according to Substance Abuse and Mental Health Services Administration (SAMHSA). In 2016, an estimated 11,824,000 individuals, or 4.4 percent of persons aged 12 and older, reported opioid misuse in the past year. According to the SAMHSA, nearly 80.0 percent of new heroin users began by abusing prescription opioids.

While the crisis has affected every demographic group in the United States, non-Hispanic whites between the ages of 18-25 seem to be most heavily impacted. In 2013, the CDC estimated the total economic burden of the opioid crisis at about $78.5 billion a year. This includes the costs of health care, lost productivity, addiction treatment, and criminal justice involvement.

New synthetic opioids that have begun to appear more frequently in the United States are intensifying the opioid crisis and increasing overdoses. Fentanyl, which is 50 times more potent than heroin, is one of the driving forces behind the continued opioid crisis. While some fentanyl is made in professional labs, much of what is available is illicitly manufactured and often mixed with heroin or cocaine, sometimes without the user's knowledge. Just 2.0 milligrams of fentanyl is enough to be lethal. Police officers and first responders are particularly at risk, as inhaling even a few airborne particles can cause an overdose. Fentanyl analogues have also been more prevalent in recent years and can be so strong that multiple doses of naloxone are required to reverse an overdose.

National Opioid Legislation

The opioid epidemic has been addressed by Congress and Presidents many times in the past three years. President Obama signed into law the Comprehensive Addiction and Recovery Act and appropriated funds to each of the 50 states through the 21st Century Cures Act. Several hundred bills have been introduced in the 115th Congress that address the opioid epidemic in some capacity. President Trump issued an executive order that created a national opioid commission, and Congress, through 2017 HR 244, appropriated $113.0 million to combat the opioid crisis.

States' Responses

The opioid crisis has now become a priority in every state. However, the impact varies considerably between states, with Kentucky, New Hampshire, Ohio, Pennsylvania, and West Virginia experiencing the largest number of overdoses. And while the opioid crisis has shown few signs of slowing, there has been some progress among states to combat further acceleration. Below are some of the approaches states have initiated.

Compact to Fight Opioid Addiction

In response to the crisis, 46 governors, including Governor Brownback, signed the Compact to Fight Opioid Addiction at the 2016 National Governors Association Winter Meeting. The Compact's goals are to reduce inappropriate opioid prescribing,change the nation's understanding of opioids and addiction, and ensure a pathway to recovery for individuals with addiction.

On March 1, 2018, Governor Colyer issued an Executive Order creating the Governor's Task Force to Address Substance Use Disorders. The Order stated the crisis of substance use disorder, particularly addiction to opioids, heroin, and methamphetamine, has truly become an epidemic in Kansas and the country. The Task Force's report is dated September 2018 and can be accessed at http://www.preventoverdoseks.org/.

Prescription Drug Monitoring Programs

Forty- nine states have a prescription drug monitoring program (PDMP) in place to track the prescribing and dispensing of all controlled substances. (*Note:* Missouri does not have a statewide PDMP; however, some Missouri counties and cities do participate in a PDMP.) State requirements vary concerning who and what is tracked, who is required or authorized to check or submit information, and the frequency information needs to be checked and updated. Many states share their data with other states' PDMPs and authorized users in those states. However, there are no federal regulations requiring states to share their information with all other states or the federal government.

Limiting Prescriptions

Some states have begun looking into placing limitations on opioid prescriptions. The Association of State and Territorial Health Officials (ASTHO) says 9 states currently have laws limiting initial opioid prescriptions to a 7-day supply instead of the previously allowed 30-day supply. The only exception is New Jersey, with a 5-day prescription limit. More states have begun to consider similar legislation as well. Other states, and even health insurance companies, are also utilizing prior authorization as a tool to limit the quantities of opioids dispensed. As of April 2018, at least 28 states had enacted legislation concerning prescription limits.

Opioid Intervention Court

Buffalo, New York, created the nation's first opioid crisis intervention court after determining its ordinary drug treatment court was not enough to combat the opioid crisis. The court gets addicts into treatment in a matter of hours instead of days; requires them to check in with a judge every day for a month; and utilizes strict curfews. It has been funded *via* a U.S. Justice Department grant with the intent of treating 200 people in a year. During the first 9 months of the program, only 1 of the 92 people in the program had overdosed.

Good Samaritan Overdose Immunity Laws

Forty states and the District of Columbia have enacted some form of a Good Samaritan or 911 drug immunity law, according to the National Conference of State Legislatures (NCSL). These laws provide immunity from arrest, charge, or prosecution for certain controlled substance possession and paraphernalia offenses when someone is either experiencing an opioid-related overdose or calling 911 to seek medical attention for someone else suffering from an opioid-related overdose. What is covered under the law varies depending on the state.

Naloxone Access

All 50 states have passed legislation to expand access to naloxone in some form. Naloxone, also known by the brand name Narcan, is an opioid antagonist that can bind to opioid receptors and reverse or block the effects of other opioids, thereby reversing opioid induced overdoses. It can be administered *via* nasal spray or injected into the outer thigh muscle, veins, or under the skin. New evidence has shown that opioid-related deaths have been reduced by 9.0 to 11.0 percent in states that have promoted naloxone. Most states have also passed laws to allow first responders to carry and administer naloxone. As of July 2017, the Prescription Drug Abuse Policy System (PDAPS) stated all 50 states have expanded the law to include the general public as well. Some states, such as Arizona, Maryland, and New Mexico, have utilized Medicaid to purchase naloxone to promote access for the public. Some states are also providing naloxone to at-risk inmates and training on how to use it upon their release from jail. Officials hope this will reduce overdose deaths as well as expand the community's knowledge about naloxone and how to use it to save others.

Medication Assisted Treatment

According to SAMHSA, 49 states have federally certified treatment locations. However, the laws concerning the programs and requirements vary by state. Medication-assisted treatment (MAT) works to normalize brain chemistry and body functions, block the euphoric effects of opioids, and relieve physiological cravings. All three Food and Drug Administration (FDA)-approved medications have different licensure requirements, with methadone requiring a SAMHSA certification, buprenorphine requiring federal licensure, and naltrexone requiring an individual licensed to prescribe medicines. According to the Commission on Combating Drug Addiction, only about 10.0 percent of conventional drug treatment facilities in the United States provide MAT for opioid addiction.

Needle Exchanges

Forty-one states and the District of Columbia have some form of a needle exchange program. Currently, only one in four drug users obtains needles from a sterile source. With the increase in the use of heroin and other drugs injected *via* needle, there is also a rise in the number of cases of HIV and hepatitis B and C. One way to help combat the spread of disease is to facilitate access to sterile needles *via* needle exchanges. The federal government lifted a ban on federal funding for needle exchanges in early 2016. Some states have also followed suit by making it easier to establish needle exchanges. Many locations provide sterile needles, test for HIV and hepatitis B and C, and provide condoms and naloxone. They will also help those who want to find treatment enter a program.

States and Cities Sue Drug Makers

Some cities and states have taken the fight against opioids to the door of opioid manufacturers. Mississippi was the first state to sue opioid manufacturers, filing lawsuits against Purdue Pharma and seven other companies. Ohio filed a lawsuit against five drug manufacturers. Missouri and Oklahoma have also initiated suits against opioid manufacturers. All the lawsuits filed by states allege that opioid manufacturers misrepresented the risks of opioids. Recently, a group of state attorneys general announced a joint investigation into the marketing and sales practices of opioid manufacturers, which they contend contributed to the opioid crisis.

Kansas

While Kansas has not been as deeply affected as other states by the opioid crisis, there were 146 opioid-related deaths in 2016. The Kansas Bureau of Investigation also saw heroin-related cases increase 87.0 percent in 2016. In response to the growing threat of the opioid crisis, Kansas has begun to implement measures to mitigate the effects. Below are some of the measures Kansas has implemented.

Prescription Drug Monitoring Programs

K-TRACS, the state prescription drug monitoring program authorized by law in 2008, has been operating since April 1, 2011. The program provides a database of controlled substance prescriptions that have been dispensed by Kansas pharmacies and from out-of-state pharmacies to Kansas residents. The purpose of the database is to provide up-to-date web-based patient information to assist prescribers in providing appropriate treatment for their patients. Additionally, drugs federally scheduled in levels II through IV are monitored.

The program requires pharmacists to document prescription dispensing data on every written controlled substance prescription and allows both prescribers and pharmacists to check prescription histories to determine, in advance, if patients are acquiring drugs from multiple prescribers or pharmacies.

Drug Treatment Courts

Kansas has not established a statewide program for drug treatment courts. However, the cities of Kansas City, Topeka, and Wichita have developed their own municipal- or county-level programs. Chase, Geary, and Lyon counties also have a drug court program. Drug treatment courts are established as an alternative to incarceration for those convicted of misdemeanors and offer treatment, support, and counseling. Many times, those who suffer from mental health disorders also suffer from addiction to drugs like opioids. For some mental health courts, diagnosis of a major mental health disorder is required for participation. However, if the participant is also addicted to drugs, treatment for that addiction will coincide with treatment for the underlying mental health disorder.

Naloxone Access

On April 7, 2017, Governor Brownback signed HB 2217 into law, expanding access to naloxone. The bill amended the Kansas Pharmacy Act to create standards governing the use and administration of emergency opioid antagonists approved by the FDA to inhibit the effects of opioids and for the treatment of an opioid overdose. The bill requires the Kansas Board of Pharmacy (Board) to issue a statewide opioid antagonist protocol, define applicable terms, establish educational requirements for the use of opioid antagonists, and provide protection from civil and criminal liability for individuals acting in good faith and with reasonable care in administering an opioid antagonist. The bill also required the Board to adopt rules and regulations necessary to implement the provisions of the bill prior to January 1, 2018. The Board met this requirement in June 2017 (KAR 68-7-23).

Grant Moneys Received

Pursuant to the 21st Century Cures Act, each of the 50 states were authorized to receive federal grant money to combat the opioid epidemic. The first half of the funding was distributed on April 17, 2017, at which time Kansas received $3.11 million from SAMHSA. Kansas' second installment of $3.11 million was released on April 18, 2018.

The FY 2017 Adult Drug Court and Veteran Treatment Courts Discretionary Grant Programs, administered by the U.S. Department of Justice, awarded the City of Wichita $398,972 to enhance its mental health court program.

Additionally, in FY 2017 the Board was awarded $178,000 under the Harold Rogers Prescription Drug Monitoring Program, administered by the U.S. Department of Justice. The funds allow prescribers in the state to submit quarterly reports and to compare their prescribing activity with other practitioners.

For more information, please contact:

Erica Haas, Principal Research Analyst
Erica.Haas@klrd.ks.gov

Jordan Milholland, Research Analyst
Jordan.Milholland@klrd.ks.gov

Katelin Neikirk, Research Analyst
Katelin.Neikirk@klrd.ks.gov

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

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KLRD

Iraida Orr
Principal Research Analyst
785-296-3181
Iraida.Orr@klrd.ks.gov

Health and Social Services

F-5 Recent Changes to Health Professions' Scope of Practice

This article provides information related to the legislative changes made to scopes of practice for health professions from 2011 to 2018. The health professions affected include the following: acupuncturists, addiction counselors, advanced practice registered nurses, applied behavior analysis service providers, dental hygienists, dentists, emergency medical services attendants, licensed practical nurses, mental health technicians, nurse-midwives, optometrists, pharmacists, pharmacy students or interns, pharmacy technicians, physical therapists, physician assistants, podiatrists, professional counselors, psychiatrists, and registered nurses. A brief summary of the Nurse Licensure Compact (2018 HB 2496) and changes related to the Behavioral Sciences Regulatory Board (BSRB) and the Board of Healing Arts that affected the licensure of multiple health professions are also included.

Acupuncturists

HB 2615 (2016) created the Acupuncture Practice Act, which provides for the licensure of acupuncturists by the Board of Healing Arts (active, exempt, and inactive licenses are created); exempts licensed physical therapists from the Acupuncture Practice Act when performing dry needling, trigger point therapy, or services specifically authorized under the Physical Therapy Practice Act; and exempts licensed acupuncturists from the Physical Therapy Practice Act. The Board of Healing Arts has adopted the required rules and regulations applicable to dry needling by physical therapists. (*Note:* See the "Physical Therapists" section in this article for additional information.)

The practice of acupuncture includes, but is not limited to the following: techniques sometimes called "dry needling," "trigger point therapy," "intramuscular therapy," "auricular detox treatment," and similar terms; mechanical, thermal, pressure, suction, friction, electrical, magnetic, light, sound, vibration, manual, and electromagnetic treatment; the use, application, or recommendation of therapeutic exercises, breathing techniques, meditation, and dietary and nutritional counselling; and the use and recommendation of herbal products and nutritional supplements, according to the acupuncturist's level of training and certification

by the National Certification Commission for Acupuncture and Oriental Medicine, or its equivalent.

The practice of acupuncture does not include prescribing, dispensing, or administering any controlled substances as defined in KSA 65-4101 *et seq*. or any prescription-only drugs, or the practice of the following: medicine and surgery, including obstetrics and the use of lasers or ionizing radiation; osteopathic medicine and surgery or osteopathic manipulative treatment; chiropractic; dentistry; or podiatry.

Additionally, the Acupuncture Practice Act provides a detailed list of the health professions exempt from acupuncture licensure.

Addiction Counselors

The Addiction Counselor Licensure Act (Act) was created by 2010 HB 2577. Any person licensed as an addiction counselor, licensed addiction counselor, or substance abuse counselor prior to enactment of the bill was prohibited from practicing without being licensed under the Act and was required to meet the applicable requirements effective August 1, 2011. The Act provided for grandfathering of certain registered or credentialed professionals.

Subsequently, changes to the scope of practice for licensed addiction counselors (LACs) and licensed clinical addiction counselors (LCACs) were made by 2011 HB 2182. Case management was removed from the scope of addiction counseling. The independent practice of addiction counseling by LCACs was expanded to include not only the diagnosis and treatment of substance abuse disorders, but also to allow for both independent practice and diagnosis and treatment of substance abuse disorders. The bill also allowed a LAC to practice in treatment facilities exempted under KSA 59-29b46(m). (Among the exempted facilities are licensed medical care facilities, licensed adult care homes, community-based alcohol and drug safety action programs, and state institutions at which detoxification services may have been obtained.) Individuals credentialed as alcohol and drug counselors who met the necessary requirements were allowed to be LCACs, engage in the independent practice of addiction counseling, and diagnose and treat substance use disorders.

SB 290 (2012) amended the Act to clarify the licensure requirements for LACs and LCACs and to address reciprocal licensure.

HB 2615 (2016) created a new category of licensure for master's level addiction counselors, who engage in the practice of addiction counseling limited to substance use disorders. Such a counselor is allowed to diagnose substance use disorders only under the direction of a LCAC, a licensed psychologist, a person licensed to practice medicine and surgery, or a person licensed to provide mental health services as an independent practitioner and whose licensure allows for the diagnosis and treatment of substance use disorders or mental disorders.

Effective September 1, 2016, pursuant to HB 2615, no person may engage in the practice of addiction counseling or represent oneself as a licensed master's addiction counselor, a master's addiction counselor, master's substance abuse counselor, or a master's alcohol and drug counselor without having first obtained a license as a master's addiction counselor. The requirement to practice only in a facility licensed by the Kansas Department for Aging and Disability Services (KDADS) was eliminated by the bill.

HB 2615 also grandfathered credentialed or registered alcohol and other drug counselors who complied with specific requirements prior to July 1, 2017. (*Note:* See page 9 for changes to the regulatory statutes administered by the BSRB for additional changes impacting multiple professions, including those involved in addiction counseling.)

Advanced Practice Registered Nurses

In 2011, HB 2182 amended the Nurse Practice Act with regard to advanced practice registered nurses (APRNs). All references to an advanced registered nurse practitioner were changed in statute to APRN, and licensure of APRNs was required.

In 2016, HB 2615 authorized the Independent Practice of Midwifery Act by certified nurse-midwives who were licensed as APRNs. Further information is included in the section on nurse-midwives.

Applied Behavior Analysis Service Providers

HB 2744 (2014) created the Applied Behavior Analysis (ABA) Licensure Act for the licensure of ABA service providers by the BSRB. ABA means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

The bill established the licensed assistant behavior analyst and the licensed behavior analyst. The bill established a January 1, 2015, effective date of Autism Spectrum Disorder (ASD) coverage by large health insurance plans and extended the requirement to grandfathered individual and small group plans effective July 1, 2016. The licensure requirements for ABA providers were phased in and certain providers were exempt from licensure.

The bill also outlined a broader range of providers allowed to receive reimbursement for ABA services from January 1, 2015, through June 30, 2016. Reimbursement narrowed beginning July 1, 2016, to services provided by an autism services provider licensed or exempt from licensure under the ABA Licensure Act, except reimbursement is allowed for services provided by an autism specialist, an intensive service provider, or any other individual qualified to provide services under the Home and Community Based Services Autism Waiver administered by KDADS.

The bill required the BSRB to adopt rules and regulations for the implementation and administration of the ABA Licensure Act, by July 1, 2016. The BSRB has established these rules and regulations (KAR 102-8-1 through 102-8-12).

In 2015, the ABA Licensure Act was amended by HB 2352 with regard to the number of employees constituting a large and small employer, terms used in connection with group health benefit plans, and the ASD coverage requirement. HB 2615 (2016) clarified the duties, powers, and functions of the BSRB as involving the regulation of individuals under several named acts, including the ABA Licensure Act.

Dental Hygienists

HB 2631 (2012) made several changes and additions to the Dental Practices Act for the purpose of expanding dental service in the state, including targeting children who are dentally underserved. The bill created an additional extended care permit (ECP) level of service of dental hygienists, ECP III, for those dental hygienists who met the increased qualifications.

An ECP III does not have prescribing authority and must be sponsored by a dentist licensed in Kansas, as confirmed by a signed agreement stating the dentist will monitor the activities of the ECP III dental hygienist. A dentist is not allowed to monitor more than five ECP III dental hygienists. The ECP III is required to advise patients and legal guardians that the services provided are palliative or preventive and are not comprehensive dental diagnosis and care.

The tasks and procedures an ECP III may perform are limited to those activities that can be performed by a hygienist under the ECP I or ECP II, plus additional tasks that include the identification and removal of decay using hand instrumentation and placing a temporary filling; services related to dentures, including adjustment and checking for sore spots; smoothing of a sharp tooth with a slow speed dental hand-piece; use of a local anesthetic within certain limitations; extraction of deciduous teeth within certain limitations; and other duties delegated by the sponsoring dentist consistent with the Dental Practices Act. The bill also detailed the population to be served by an ECP III.

Dentists

HB 2182 (2011) amended the Dental Practices Act to allow for the franchise practice of dentistry. The bill also allowed licensed dentists to practice dentistry as employees of a general hospital in counties with populations of less than 50,000.

A special volunteer dental license was established in HB 2631 (2012) for dentists who are retired from active practice and wish to donate their expertise for the dental care and treatment of indigent and underserved persons in Kansas. The bill set forth stipulations related to this license, including that no payment of an application fee, license fee, or renewal fee is required and no continuing education is required for issuance or renewal.

Dentists with a special volunteer dental license are limited to providing dental care without payment or compensation only to underserved and indigent persons in the state.

Emergency Medical Services Attendants

The statutory changes made by House Sub. for SB 262 in 2010, allowing Emergency Medical Services (EMS) attendants to transition from authorized activities to a scope of practice established by the Kansas Board of Emergency Medical Services (Board) through rules and regulations, renaming attendant levels to reflect national nomenclature, and allowing for enhanced skill sets to create the ability to provide a higher level of care, were amended in 2011 by HB 2182. The 2011 changes were to support the transition and to provide options for those required to meet the transition requirements. EMS attendants were allowed the option to transition to a lower level of certification.

In addition, the 2011 changes allowed an emergency medical technician–intermediate (EMT-I), an advanced emergency medical technician (AEMT), an emergency medical technician (EMT), an EMT-defibrillator (EMT-D), and an emergency medical responder (EMR) to provide medical services within their scope of practice when authorized by medical protocols or upon order when direct voice communication was maintained and monitored by specific authorized medical personnel.

In 2011, HB 2182 also changed the initiation date to allow attendants complete certification cycles to accomplish the transition requirements and provided the conditions to be met by each EMS certificate holder to transition to a higher level. The scopes of practice of an EMT-I, an AEMT, an EMT, an EMT-D, and an EMR were set out in detail by the bill. The term “medical advisor” was replaced with “medical director” and each EMS was required to have a medical director whose duties included the implementation of medical protocols and the approval and monitoring of the attendants’ education.

In 2016, HB 2387 made changes to the authorized activities of those who have certain EMS certifications. Under continuing law, each classification of EMS attendant is authorized to perform the interventions of the lower levels of certified attendants. The bill changed authorized activities by an EMT-I transitioning to an AEMT and updated and changed authorized activities by EMTs and EMRs. The terms EMT, EMT-I, EMT-D, mobile intensive care technician (MICT), EMT-I/D, AEMT, and paramedic were removed from the list of those individuals of whom at least one must be on each vehicle providing emergency medical services and the list was replaced with a reference to an attendant certified under statutes applicable to those listed categories.

In 2018, SB 311 added EMS attendants to the list of mandatory reporters of abuse, neglect, exploitation, or need of protective services as it pertains to a resident or certain adults (as defined in continuing law). The applicable definition in continuing law for “resident” is found in KSA 2018 Supp. 39-1401(a) and for “adult” in KSA 2018 Supp. 39-1430(a). The definition of “adult” excludes residents of adult care homes.

Mental Health Technicians

In 2017, HB 2025 amended the Mental Health Technician’s Licensure Act. The bill changed the description of services in the definition of “practice of mental health technology” by deleting

"responsible nursing for patients with mental illness or intellectual disability" and inserting "participation and provision of input into the development of person-centered treatment plans for individuals or groups of individuals specified in paragraph (b)" (those specified in paragraph (b) are "the mentally ill, emotionally disturbed, or people with intellectual disability") and by including facilitating habilitation of individuals. The bill also replaced the term "patient" with "individual."

Nurse-Midwives

The Independent Practice of Midwifery Act (Midwifery Act) was created by 2016 HB 2615. Effective January 1, 2017, the Midwifery Act allows certified nurse-midwives to practice without a collaborative practice agreement under specific conditions set forth below and requires the certified nurse-midwife to hold a license from the Board of Nursing as an APRN and the Board of Healing Arts for the independent practice of midwifery. The bill required the Board of Healing Arts, in consultation with the Board of Nursing, to promulgate rules and regulations no later than January 1, 2017, pertaining to certified nurse-midwives engaging in the independent practice of midwifery and governing the ordering of tests, diagnostic services, prescribing of drugs, and referral or transfer to physicians in the event of complications or emergencies.

On December 8, 2017, the Board of Healing Arts considered and formally approved proposed regulations, which were forwarded to the Board of Nursing. On March 28, 2018, upon consideration of concerns expressed by its APRN Committee, the Board of Nursing declined the regulations and referred them back to the Board of Healing Arts for consideration of nationally recognized standards of practice. General Counsel for the Board of Healing Arts appeared before the Board of Nursing at its September 2018 meeting to request the Board of Nursing concur on the proposed regulations, or in the alternative, specify the portions of any regulations to which they objected and propose revisions or alternatives to those portions. At that meeting, the Board of Nursing voted to concur on 14 of the 18 proposed regulations and nonconcur on the 4 remaining regulations. The Board of Nursing agreed to provide the Board of Healing Arts with proposed alternatives to the nonconcurred regulations. All of the concurred regulations have been submitted to the Department of Administration for review. The Board of Healing Arts, at its October 12, 2018, meeting, discussed the language proposed by the Board of Nursing for the four remaining nonconcurred regulations. Counsel for both boards are in the process of exchanging proposed changes to determine if the differences can be resolved.

"Independent practice of midwifery" means the provision of clinical services by a certified nurse-midwife without the requirement of a collaborative practice agreement with a person licensed to practice medicine and surgery. The clinical services are limited to those associated with a normal, uncomplicated pregnancy and delivery, including the prescription of drugs and diagnostic tests; the performance of an episiotomy or a repair of a minor vaginal laceration; the initial care of the normal newborn; and family planning services, including treatment or referral of a male partner for sexually transmitted infections.

The standards of care in the ordering of tests, diagnostics services, and the prescribing of drugs shall be those standards that protect patients and are comparable to those for persons licensed to practice medicine and surgery providing the same services.

The bill also prohibited nurse-midwives engaged in the independent practice of midwifery from performing or inducing abortions or from prescribing drugs for an abortion.

Optometrists

In 2012, HB 2525 updated the optometry law to reflect the single licensure level of optometrists required by the Board of Examiners in Optometry by eliminating language referring to three different levels of licensure, as well as clarifying the minor surgical procedures optometrists may perform.

Pharmacists, Pharmacy Students or Interns, and Pharmacy Technicians

The Pharmacy Act was amended by 2012 SB 211 to add a second exception to the requirement that pharmacists fill all prescriptions in strict conformity with the directions of the prescriber. The exception allows a pharmacist to provide up to a three-month supply of a prescription drug that is not a controlled substance or a psychotherapeutic drug when a practitioner has written a drug order to be filled with a smaller supply, but the prescription includes enough refills to fill a three-month supply.

Another statutory exception allows a pharmacist who receives a prescription order for a brand-name drug to substitute a different brand in order to achieve a lesser cost to the purchaser, unless the prescriber has instructed the prescription be dispensed as written or as communicated, or the federal Food and Drug Administration has determined the generic prescription medication is not bioequivalent to the prescribed brand name prescription medication.

Senate Sub. for HB 2055 (2017) added a third exception to the requirement prescriptions be filled in strict conformity with any directions of the prescriber concerning biological products. The bill allows a pharmacist to exercise brand exchange (substitution) without prior approval from the prescriber, unless certain conditions exist. A pharmacist who receives a prescription order for a biological product may exercise brand exchange with a view toward achieving a lesser cost to the purchaser, unless the prescriber has instructed the prescription be dispensed as written or as communicated or the biological product is not an interchangeable biological product for the prescribed biological product. The bill required pharmacists to notify the patient and prescriber of the substitution of a biological product after the exchange has occurred and established recording requirements for biological product substitutions.

The bill also defined "biological product" and "interchangeable biological product" and clarified the definition of a "brand exchange" to distinguish between a brand exchange for a prescribed drug product and brand exchange for a prescribed biological product, provided for emergency refills of biological products by pharmacists, and addressed allowable charges for brand exchange of biological products.

Additionally, the bill required the Board of Pharmacy to adopt rules and regulations restricting the tasks a pharmacy technician may perform prior to passing any required examinations and required every pharmacy technician registered after July 1, 2017, to pass a certified pharmacy technician examination approved by the Board of Pharmacy. The Board of Pharmacy established rules and regulations addressing the certification of required examinations and requests for extension. However, the Board of Pharmacy determined additional practice limitations prior to passage of the certification exam should not be imposed because it would place too many restrictions on on-the-job training.

Senate Sub. for HB 2146 (2014) amended the "practice of pharmacy" definition to include performance of collaborative drug therapy management pursuant to a written collaborative practice agreement with one or more physicians who have an established physician-patient relationship. Other definitions added to the Pharmacy Act were "collaborative practice agreement" and "collaborative drug therapy management."

A collaborative practice agreement is a written agreement or protocol between one or more pharmacists and one or more physicians providing for collaborative drug therapy management.

The collaborative practice agreement must contain conditions or limitations pursuant to the collaborating physician's orders and be within the physician's lawful scope of practice and appropriate to the pharmacist's training and experience.

Collaborative drug therapy management allows a pharmacist to perform patient care functions for a specific patient delegated to the pharmacist by a physician through a collaborative practice agreement. A physician who enters into an agreement remains responsible for the care of

the patient throughout the collaborative drug therapy management process. Under this management process, a pharmacist cannot alter a physician's orders or directions, diagnose or treat any disease, independently prescribe drugs, or independently practice medicine and surgery.

The bill also provided for the registration, discipline, training, and oversight of pharmacist interns. These new provisions relating to pharmacist interns are considered part of the Pharmacy Act. The bill authorized the Board of Pharmacy to adopt rules and regulations necessary to ensure pharmacist interns are adequately trained as to the nature and scope of their duties. No such rules or regulations have been adopted as of September 12, 2018. Pharmacist interns must work under the direct supervision and control of a pharmacist who is responsible to determine the pharmacist intern is in compliance with applicable rules and regulations of the Board of Pharmacy and is responsible for the acts and omissions of the pharmacist intern in performing the intern's duties.

The Pharmacy Act was amended in 2017 HB 2030 to change, from 18 to 12 years of age, the minimum age for a person to whom a pharmacist, or a pharmacy student or intern working under the direct supervision and control of a pharmacist, is authorized to administer a vaccine, other than the influenza vaccine, pursuant to a vaccination protocol and with the requisite training. Continuing law requires immunizations provided under the authorization of the Pharmacy Act be reported to appropriate county or state immunization registries. The bill allowed the person vaccinated or, if the person is a minor, the parent or guardian of the minor, to opt out of the registry reporting requirement.

Physical Therapists

In 2013, HB 2066 amended the Physical Therapy Practice Act to allow physical therapists to initiate a physical therapy treatment without referral from a licensed health care practitioner. In prior law, physical therapists were allowed only to evaluate patients without physician referrals and to initiate treatment only after approval by certain health care providers.

The bill also required physical therapists, in instances where treatment of a patient occurs without a referral, to obtain a referral from an appropriate licensed health care practitioner to continue treatment if, after 10 patient visits or a period of 15 business days from the initial treatment visit (following the initial evaluation), the patient is not progressing toward documented treatment goals as demonstrated by objective, measurable, or functional improvement, or any combination of these criteria.

When a patient self-refers to a physical therapist, the physical therapist is required, prior to commencing treatment, to provide written notice to the patient that a physical therapy diagnosis is not a medical diagnosis by a physician. The bill also provided that new provisions of law created by the bill were not to be construed to prevent a hospital or ambulatory surgical center from requiring a physician order or referral for physical therapy services for a patient currently being treated in such facility.

HB 2066 also authorized physical therapists to perform wound debridement services only after approval by a person licensed to practice medicine and surgery or other licensed health care practitioner in appropriately related cases. The bill deleted the requirements limiting physical therapists to evaluation of patients without a physician referral and the conditions and time frame specified for permitted evaluation and treatment without referral. Prior to this bill, physical therapists were permitted to initiate treatment only after approval by a licensed physician; a licensed podiatrist; a licensed physician assistant or a licensed advanced practice registered nurse, working pursuant to the order or direction of a licensed physician; a licensed chiropractor; a licensed dentist; or a licensed optometrist in appropriately related cases. The bill also deleted provisions authorizing physical therapists to initiate treatment under the approval of a healing arts practitioner licensed by another state.

HB 2615 (2016) amended the Physical Therapy Practice Act to include the practice of dry

needling within the scope of practice for licensed physical therapists, exempted licensed physical therapists from the Acupuncture Practice Act when performing dry needling, and exempted licensed acupuncturists from the Physical Therapy Practice Act. The Board of Healing Arts has adopted the required rules and regulations applicable to dry needling (KAR 100-29-18 through 100-29-21).

Physician Assistants

HB 2673 (2014) made changes to the Kansas Physician Assistant Licensure Act to replace the statutory limitation on the number of physician assistants (PAs) who may be supervised by a physician and directed the Board of Healing Arts to establish regulations imposing limits appropriate to different patient care settings and creating new licensure designations for PAs. In 2015, Senate Sub. for HB 2225 amended the statutory limitation on the number of PAs a physician may supervise to two until January 11, 2016.

The bill also created licensure designations of "active license" and "licensure by endorsement," and eliminated the designation of a "federally active license."

Additionally, the practice of a PA was expanded to allow a PA, when authorized by a supervising physician, to dispense prescription-only drugs according to rules and regulations adopted by the Board of Healing Arts governing prescription-only drugs, when dispensing is in the best interest of the patient and pharmacy services are not readily available, and the amount dispensed is not in excess of the quantity necessary for a 72-hour supply. The effective date of a PA's authority to dispense prescription-only drugs was amended by Senate Sub. for HB 2225 to an effective date of January 11, 2016.

Senate Sub. for HB 2225 amended the Physician Assistant Licensure Act to create the designations of "exempt license" and "federally active license."

An "exempt license" may be issued to a licensed PA who is not regularly engaged in PA practice in Kansas and does not hold himself or herself out publicly to be engaged in such practice. An exempt licensee is entitled to all privileges of a PA, is subject to all provisions of the Physician Assistant Licensure Act, and is allowed to be a paid employee of a local health department or an indigent health care clinic.

The Board of Healing Arts may issue a "federally active license" to a licensed PA who practices as a PA solely in the course of employment or active duty with the federal government. Under this designation, a person may engage in limited practice outside the course of federal employment consistent with the scope of practice of the exempt licensees, except the scope is limited to performing administrative functions; providing direct patient care services gratuitously or providing supervision, direction, or consultation for no compensation (payment for subsistence allowances or actual and necessary expenses incurred in providing such services is allowed); and rendering professional services as a charitable health care provider.

Senate Sub. for HB 2225 also allowed a PA to write do-not-resuscitate (DNR) orders if delegated the authority by a physician, and revised the DNR statutory form to include a PA signature line.

It should be noted, with the enactment of 2017 Sub. for SB 85 (Simon's Law), a DNR or similar physician's order cannot be instituted for an unemancipated minor unless at least one parent or legal guardian of the minor has been informed, orally and in writing, of the intent to institute the order. A reasonable attempt to inform the other parent must be made if the other parent is reasonably available and has custodial or visitation rights. The information need not be provided in writing if, in reasonable medical judgment, the urgency of the decision requires reliance on providing the information orally. The bill provides that either parent or the unemancipated minor's guardian may refuse consent for a DNR or similar order, either orally or in writing. Further, the bill provides that no DNR or similar order can be instituted, orally or in writing, if there is a refusal of consent.

Senate Sub. for HB 2225 also changed "written protocol" to "written agreement" and "responsible physician" to "supervising physician" with regard

to the authority of a PA to prescribe drugs. The bill reverted to the use of the terms in law prior to July 1, 2014, but only until January 11, 2016, when the new terms became effective. Supervising physician means a physician who has accepted responsibility for the medical services rendered and the actions of the PA while performing under the direction and supervision of the supervising physician. The Board of Healing Arts has adopted the required rules and regulations governing the practice of PAs.

Podiatrists

The Podiatry Act was amended by 2014 HB 2673 to expand and clarify the scope of podiatry and podiatric surgery and to create a Podiatry Interdisciplinary Advisory Committee to the Board of Healing Arts to advise and make recommendations on matters relating to the licensure of podiatrists to perform surgery on the ankle. "Podiatry" was previously defined as the diagnosis and treatment of all illnesses of the human foot. The bill changed the definition of "podiatry" to mean the diagnosis and medical and surgical treatment of all illnesses of the human foot, including the ankle and tendons that insert into the foot, as well as the foot. The bill prohibits podiatrists from performing ankle surgery unless the podiatrist has completed a three-year post-doctoral surgical residency program in reconstructive rear foot/ankle surgery and is either board-qualified (progressing to certification) or board-certified in reconstructive rear foot/ankle surgery by a nationally recognized certifying organization acceptable to the Board of Healing Arts. Surgical treatment of the ankle by a podiatrist is required to be performed only in a medical care facility.

Professional Counselors

SB 386 (2018) amended the Professional Counselors Licensure Act with regard to educational requirements for licensure as a professional counselor. In continuing law, an applicant to the BSRB for licensure as a professional counselor is required, among other things, to have earned a graduate degree in counseling. The bill allows licensure for an applicant who earned a graduate degree in a counseling-related field if the remaining qualifications set forth in statute are met. The change applies to individuals applying for initial licensure and to individuals applying for licensure who are licensed to practice professional counseling in another jurisdiction.

The bill also clarified the licensure requirement of 45 graduate semester hours in various areas set forth in statute is counseling coursework.

Psychiatrists

HB 2615 (2016) provided for a temporary license, not to exceed two years, to be issued to persons who have completed all requirements for a doctoral degree approved by the BSRB, but have not received such degree conferral, and who provide documentation of such completion.

Other Changes Related to Licensure of Health Professions

Changes made from 2014 to 2018 related to the BSRB, the Board of Healing Arts, and the Board of Nursing that affected multiple health professions are outlined below.

Board of Nursing

HB 2496 (2018) enacted the Nurse Licensure Compact (Compact) and amended the Kansas Nurse Practice Act to enable the Board of Nursing to carry out the provisions of the Compact and establish the duties of registered nurses (RNs) and licensed practical nurses (LPNs) under the Compact. The Compact allows RNs and LPNs to have one multi-state license, with the privilege to practice in the home state of Kansas and in other Compact states physically, electronically, telephonically, or any combination of those.

The bill takes affect from and after July 1, 2019, and upon publication in the statute book.

Behavioral Sciences Regulatory Board

HB 2615 (2016) standardized regulatory statutes administered by the BSRB that apply

to psychologists, professional counselors, social workers, addiction counselors, and marriage and family therapists. The bill clarified the duties, powers, and functions of the BSRB as involving the regulation of individuals under the Social Workers Licensure Act, the Licensure of Master's Level Psychologists Act, the Applied Behavior Analysis Licensure Act, the Marriage and Family Therapists Licensure Act, and the Addiction Counselor Licensure Act. The standardized provisions pertain to licensure by reciprocity, the reasons for disciplinary action against a licensee, and the licensure fees charged by the BSRB.

The bill allows the BRSB to require fingerprinting and background checks on licensees, places licensed psychologists and social workers under the Kansas Administrative Procedure Act, establishes supervisory training standards for professional counselors and marriage and family therapists, and creates a new category of licensure for master's level addiction counselors.

Additionally, the bill requires a two-thirds majority vote of the BSRB to issue or reinstate the license of an applicant with a felony conviction. The bill updates several statutes by deleting the terms "state certified alcohol and drug abuse counselor" and "counselor" from applicable statutes and inserting "licensed addiction counselor," "licensed master's addiction counselor," and "licensed clinical addiction counselor" into applicable statutes.

Healing Arts Act

HB 2673 (2014) amended provisions of the Healing Arts Act related to institutional licenses. The bill removed the requirement for applicants who attend out-of-state schools of medicine or osteopathic medicine to have attended a school that has been in operation for at least 15 years. The requirement that the applicant has attended an institution whose graduates have been licensed in a state or states with standards similar to Kansas remains.

The bill removed the option for an institutional license holder to provide mental health services pursuant to written protocol with a person who holds a license that is not an institutional license. Instead, the institutional license holder is required to meet the previously optional requirements of employment by certain mental health facilities for at least three years and requiring the institutional license holder's practice be limited to providing mental health services that are a part of the licensee's paid duties and are performed on behalf of the employer.

However, in 2017, Senate Sub. for HB 2027 amended the statute governing institutional licenses and restrictions placed on practice privileges of these license holders. The bill reinserted the language removed in 2014 to allow for reinstatement of an institutional license of an individual who was issued an institutional license prior to May 9, 1997, and who is providing mental health services under a written protocol with a person who holds a Kansas license to practice medicine and surgery other than an institutional license.

The Healing Arts Act was again amended by 2015 Senate Sub. for HB 2225 to clarify a reentry license must be an "active" reentry license and to create a resident active license. A resident active licensee is entitled to all privileges attendant to the branch of the healing arts for which such license is used. A resident active license can be issued to a person who has successfully completed at least one year of approved postgraduate training; is engaged in a full-time, approved postgraduate training program; and has passed the examinations for licensure. The Board of Healing Arts is required to adopt rules and regulations regarding issuance, maintenance, and renewal of the license. The Board of Healing Arts submitted KAR 100-6-2a, pursuant to KSA 65-2873b, to the Department of Administration in July 2018. The regulation is pending approval by the Department of Administration, the Division of the Budget, and the Attorney General.

Additionally, Senate Sub. for HB 2225 expanded the scope of the "special permit"—to include the practice of medicine and surgery—that may be issued by the Board of Healing Arts to any person who has completed undergraduate training at the University of Kansas School of Medicine who has not yet commenced a full-time approved

postgraduate training program. The holder of the special permit is allowed to be compensated by a supervising physician, but is not allowed to charge patients a fee for services rendered; is not allowed to engage in private practice; is allowed to prescribe drugs, but not controlled substances; is required to clearly identify himself or herself as a physician in training; is not deemed to be rendering professional service as a health care provider for the purposes of professional liability insurance; is subject to all provisions of the Healing Arts Act, except as otherwise provided in the bill; and is required to be supervised by a physician who is physically present within the health care facility and is immediately available.

The special permit expires the day the holder of the permit becomes engaged in a full-time approved postgraduate training program or one year from issuance. The permit may be renewed one time. The Board of Healing Arts is allowed to adopt rules and regulations to carry out the provisions related to the special permit holder. The Board has not identified a need for regulations specific to special permit holders, other than the generally applicable regulations already in existence.

For more information, please contact:

Iraida Orr, Principal Research Analyst
Iraida.Orr@klrd.ks.gov

Erica Haas, Principal Research Analyst
Erica.Haas@klrd.ks.gov

Melissa Renick, Assistant Director for Research
Melissa.Renick@klrd.ks.gov

Whitney Howard, Principal Research Analyst
Whitney.Howard@klrd.ks.gov

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

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KLRD

Whitney Howard
Principal Research Analyst
785-296-3181
Whitney.Howard@klrd.ks.gov

Health and Social Services

F-6 Recent Telemedicine Legislation in Kansas

Telemedicine legislation was introduced during the 2017 and 2018 Legislative Sessions. This article discusses the legislative history of those bills and provides summary information on the Kansas Telemedicine Act (Act), KSA 2018 Supp. 40-2,210 *et seq.*, and other provisions enacted in 2018 Senate Sub. for HB 2028.

Recent Telemedicine-related Legislation

During the 2017 Legislative Session, two pieces of telemedicine-related legislation were introduced and referred to the House Committee on Health and Human Services (House Committee), HB 2206 and HB 2254. Hearings were held on these bills, but no action was taken at that time. The Legislative Coordinating Council, in 2017, appointed a Special Committee on Health, which was tasked with studying the subjects of telehealth and telemedicine in order to increase and improve health care access for all Kansans, and review and consider the two bills.

The Special Committee, in its meetings on October 19 and 20, 2017, viewed demonstrations of telemedicine technologies; heard testimony from individuals, organizations, and providers; and participated in a roundtable discussion with select stakeholders. Following discussion, the Special Committee noted the importance of keeping the patient first when crafting legislation; did not recommend 2017 HB 2206 or 2017 HB 2254; and recommended the introduction of comprehensive telemedicine legislation, to begin in the House, early in the 2018 Legislative Session.

During the 2018 Legislative Session, the House Committee held hearings on two telemedicine bills, HB 2512 and HB 2674. The House Committee did not take action on HB 2512, but referenced the testimony of HB 2512 during the hearing on HB 2674. HB 2674 was amended by both the House Committee and the Senate Committee on Public Health and Welfare, and eventually inserted into Senate Sub. for HB 2028 as the report from the third Conference Committee. Senate Sub. for HB 2028 was approved by the Governor on May 12, 2018.

The majority of the provisions contained in Senate Sub. for HB 2028 will take effect on and after January 1, 2019. The Board of Healing Arts (BOHA) and the Behavioral Sciences Regulatory

Board (BSRB) are required to adopt rules and regulations related to the Act by December 31, 2018.

Additionally, Senate Sub. for HB 2028 provided for coverage of speech-language pathologist and audiologist services *via* telehealth under the Kansas Medical Assistance Program (KMAP), if such services would be covered under KMAP when delivered *via* in-person contact. The Kansas Department of Health and Environment (KDHE) is required to adopt rules and regulations related to coverage of these services by December 31, 2018.

Summary of Provisions Contained in Senate Sub. for HB 2028

Definition of "Telemedicine" and How Services are Provided

The Act defines "telemedicine, including telehealth" as the delivery of healthcare services or consultations while the patient is at an originating site and the healthcare provider is at a distant site. The "distant site" is the site at which a healthcare provider is located while providing healthcare services *via* telemedicine, and the "originating site" is the site at which a patient is located at the time healthcare services are provided.

The Act directs telemedicine services to be provided by means of real-time two-way interactive audio, visual, or audio-visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support healthcare delivery that facilitates the assessment, diagnosis, consultation, treatment, education, and care management of a patient's healthcare. "Telemedicine," for purposes of the Act, does not include communication between healthcare providers consisting solely of a telephone voice-only conversation, e-mail, or facsimile transmission, or between a physician and a patient consisting solely of an e-mail or facsimile transmission.

Standards and Practices Applicable to Telemedicine Services

The Act specifies the same requirements for patient privacy and confidentiality under the Health Insurance Portability and Accountability Act of 1996 and 42 CFR § 2.13 (related to confidentiality restrictions and safeguards), as applicable, applying to healthcare services delivered *via* in-person visits also apply to healthcare visits delivered *via* telemedicine. The Act does not supersede other state law related to the confidentiality, privacy, security, or privileged status of protected health information.

The Act authorizes telemedicine to be used to establish a valid provider-patient relationship and requires the same standards of practice and conduct that apply to healthcare services delivered *via* in-person visits apply to healthcare services delivered *via* telemedicine. A person authorized by law to provide and who provides telemedicine services to a patient is required to provide the patient with guidance on appropriate follow-up care.

Additionally, if the patient consents and has a primary care or other treating physician, the person providing telemedicine services is required to send a report to the primary care or other treating physician of the treatment and services rendered to the patient within three business days of the telemedicine encounter. A person licensed, registered, certified, or otherwise authorized to practice by the BSRB is not required to comply with this reporting requirement.

Application of Insurance Policies, Contracts, and KMAP to Telemedicine under the Act

The Act applies to any individual or group health insurance policy, medical service plan, contract, hospital service corporation contract, hospital and medical service corporation contract, fraternal benefit society, or health maintenance organization that provides coverage for accident and health services delivered, issued for delivery, amended, or renewed on or after January 1, 2019. The Act also applies to KMAP.

The policies, plans, contracts, and KMAP are prohibited from excluding an otherwise covered healthcare service from coverage solely because the service is provided through telemedicine rather than in-person contact or based upon the lack of a commercial office for the practice of medicine, when such service is delivered by a healthcare provider. The Act prohibits such groups from requiring a covered individual to use telemedicine or in lieu of receiving in-person healthcare service or consultation from an in-network provider.

The Act specifies these groups shall not be prohibited from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered individual's health benefits plan. The insured's medical record serves to satisfy all documentation for the reimbursement of all telemedicine healthcare services, and no additional documentation outside the medical record is required.

Additionally, the Act authorizes an insurance company, nonprofit health service corporation, nonprofit medical and hospital service corporation, or health maintenance organization to establish payment or reimbursement of covered healthcare services delivered through telemedicine in the same manner as payment or reimbursement for covered services delivered *via* in-person contact. However, the Act does not mandate coverage for a healthcare service delivered *via* telemedicine if such service is not already a covered service when delivered by a healthcare provider, and subject to the terms and conditions of the covered individual's health benefits plan.

Prohibition on Delivery of Abortion Procedures via Telemedicine

Nothing in the Act is construed to authorize the delivery of any abortion procedure *via* telemedicine.

Severability and Non-severability Clauses

If any provision of the Act, or the application thereof to any person or circumstance, is held invalid or unconstitutional by court order, the remainder of the Act and application of such provision is not affected. Additionally, it is conclusively presumed the Legislature would have enacted the remainder of the Act without the invalid or unconstitutional provision. Further, the provision of the Act related to abortion is expressly declared to be non-severable. If the abortion language is held invalid or unconstitutional by court order, the entire Act is affected.

Other Provisions Included in Legislation, but Not Part of the Act

The following provisions of 2018 Senate Sub. for HB 2028 are not included in the Act.

Coverage of Speech-Language Pathology and Audiology Services

Coverage Requirement under KMAP

On and after January 1, 2019, KDHE and any managed care organization providing state Medicaid services under KMAP is required to provide coverage for speech-language pathology services and audiology services by means of telehealth, as defined in the Act, when provided by a licensed speech-language pathologist or audiologist licensed by the Kansas Department for Aging and Disability Services if such services are covered by KMAP when delivered *via* in-person contact.

Implementation and Administration by KDHE

KDHE is required to implement and administer the coverage of these services consistent with applicable federal laws and regulations. KDHE is required to submit to the Centers for Medicare and Medicaid Services any state Medicaid plan amendment, waiver request, or other necessary approval request.

Impact Report

On or before January 13, 2020, KDHE is required to prepare an impact report that assesses the social and financial effects of the coverage

mandated for speech-language pathology and audiology services, including the impacts listed in KSA 40-2249(a) and (b) relating to social and financial impacts of mandated health benefits. KDHE is required to submit such report to the Legislature, the House Committee on Health and Human Services, the House Committee on Insurance, the Senate Committee on Public Health and Welfare, and the Senate Committee on Financial Institutions and Insurance.

Application of the Act to Insurance Policies

Senate Sub. for HB 2028 amended KSA 2018 Supp. 40-2,103 to specify the requirements of the Act apply to all insurance policies, subscriber contracts, or certificates of insurance delivered, renewed, or issued for delivery within or outside of Kansas, or used within the state by or for an individual who resides or is employed in the state.

Corporations Under the Nonprofit Medical and Hospital Service Corporation Act

Senate Sub. for HB 2028 amended KSA 2018 Supp. 40-19c09 to specify corporations organized under the Nonprofit Medical and Hospital Service Corporation Act are subject to the provisions of the Act.

For more information, please contact:

Whitney Howard, Principal Research Analyst
Whitney.Howard@klrd.ks.gov

Iraida Orr, Principal Research Analyst
Iraida.Orr@klrd.ks.gov

Erica Haas, Principal Research Analyst
Erica.Haas@klrd.ks.gov

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181

KLRD

David Fye
Principal Fiscal Analyst
785-296-3181
David.Fye@klrd.ks.gov

Health and Social Services

F-7 State Hospitals

The Kansas Department for Aging and Disability Services (KDADS) is responsible for the administration of Larned State Hospital (LSH) and Osawatomie State Hospital (OSH) for Kansans suffering from mental illness, and for the Kansas Neurological Institute (KNI) and Parsons State Hospital and Training Center (PSH&TC) for individuals with intellectual and developmental disabilities. An overview of issues related to the state hospitals, summaries of recent legislation, and an overview of state hospital financing are provided in this article.

Osawatomie State Hospital

OSH, established in 1855, provides services to adults diagnosed with psychiatric disorders, regardless of ability to pay or legal status. OSH is licensed by the Kansas Department of Health and Environment (KDHE) to serve a maximum of 206 patients and currently serves 146 individuals from 44 counties in Kansas in collaboration with 12 Community Mental Health Centers. These centers refer individuals to OSH through a screening process; however, a moratorium on voluntary admissions and a limit on involuntary admissions was issued in June 2015.

In addition to being licensed by KDHE, OSH receives oversight and certification from the federal Centers for Medicare and Medicaid Services (CMS). CMS issues Medicare and Medicaid Disproportionate Share for Hospital (DSH) programs payments to OSH. In December 2015, CMS decertified OSH and subsequently suspended Medicare and DSH payments.

Decertification. In 2014, OSH began having issues with maintaining census. OSH was over-census for 9 months from March 3 through December 6, 2014. The number of patients at OSH reached an overall 10-year high on August 23, 2014, with a weekly average of 251 patients. (OSH began maintaining census at its licensed capacity on December 13, 2014.) The increased census during this 9-month period triggered a CMS survey of OSH. On December 5, 2014, CMS sent a letter citing issues with the physical environment at OSH that had to be remediated to maintain certification. Renovations to complete a Plan of Correction for CMS began in Spring 2015. In May 2015, 60 beds were removed from use to complete the CMS-mandated construction. Approximately $3.5 million was added in a 2016 Governor's Budget Amendment

to support individuals and communities impacted by the OSH reduced census during renovation.

On November 3, 2015, CMS conducted another survey at OSH amid concerns the nursing service requirements were not being met. On November 24, 2015, CMS released its survey findings stating, among other things, various nursing security protocols were not being followed. On December 21, 2015, CMS decertified OSH, citing the facility for issues related to patient health and safety. The main impact on funding was through the loss of DSH and Medicare reimbursements for any patients who would have been eligible during their treatment at OSH. (As of October 2017, OSH is still taking patients in accordance with the moratorium; CMS decertification pertains to billing rather than admissions.) The Kansas Department for Aging and Disability Services (KDADS) estimates that during the period the hospital is decertified, the loss in combined revenue is roughly $1.0 million per month, starting January 2016, until the hospital is recertified.

On May 8th, 2017, federal CMS surveyors conducted a full recertification survey for the 60 beds of Adair Acute Care (AAC) at OSH. On June 9, 2017, CMS released a report citing OSH for sanitation issues related to the kitchen, disease control for patients, and internal policies needing revisions. KDADS took corrective actions and requested CMS to revisit. In August and November 2017, CMS returned to survey issues previously cited at AAC and found no issues with AAC for these limited scope deficiency surveys. In December 2017, CMS notified OSH the 60 beds that comprise AAC were recertified for federal reimbursements and the hospital would begin to receive partial DSH payments.

Moratorium. The Secretary for Aging and Disability Services (Secretary) declared a moratorium on OSH admissions on June 21, 2015, to control census during construction. OSH did not close, nor stop admitting new patients; rather, admission of voluntary patients was halted, the census for involuntary patients was capped at 146, and a waiting list was created. KSA 59-2968 authorizes the Secretary to notify the Kansas Supreme Court and each district court with jurisdiction over all or part of the catchment area served by a state psychiatric hospital that the census of a particular treatment program of that state psychiatric hospital has reached capacity and no more patients may be admitted. Following notification that a state psychiatric hospital program has reached its capacity and no more patients may be admitted, any district court with jurisdiction over all or part of the catchment area served by that state psychiatric hospital, and any participating mental health center that serves all or part of that same catchment area, may request that patients needing that treatment program be placed on a waiting list maintained by that state psychiatric hospital. Patients are admitted in chronological order. In July 2017, OSH increased its patient census to 158 and at the Legislative Budget Committee (LBC) meeting on October 3, 2018, the Secretary indicated OSH had increased its staffing to accommodate 166 patients. The Secretary informed the LBC that while OSH has the capacity to provide treatment to 166 patients, the patient census had been in the range of 130 for the past fiscal year due in part to regional efforts such as crisis unit beds, and OSH was considering lifting the moratorium on voluntary admissions.

Larned State Hospital

LSH, located in south-central Kansas, is the largest psychiatric facility in the state and serves the western two-thirds of the state. The hospital serves adults with serious and persistent mental illnesses, most of whom have been deemed a danger to themselves or others. LSH has a Sexual Predator Treatment Program (SPTP) to treat offenders who have completed their prison sentences but have been involuntarily committed because a judge or jury found they were “sexually violent predators,” which means they have a “mental abnormality or personality disorder” that makes it likely they will engage in sexual violence again if not treated. The psychiatric services program at LSH is certified by CMS.

The SPTP, established by statute in 1994, provides for the civil commitment of persons identified by the law as sexually violent predators. KDADS states the program’s two missions are to provide for the safety of Kansas citizens by establishing

a secure environment in which persons identified as sexually violent predators can reside and to offer treatment with the aim of reducing their risk for re-offending while allowing motivated persons who complete treatment to return to society. The program serves adult male patients from the state who have been adjudicated through Kansas sexually violent predator treatment laws and are committed for treatment under civil statues. In FY 2018, the average daily census for the SPTP program at the LSH campus totaled 236 patients and the average at the reintegration units totaled 26 patients.

Legislative Post Audits. The Legislative Division of Post Audit (LPA) completed two performance audits on the SPTP. The first, published in September 2013, looked at whether the program was appropriately managed to ensure the safety and well-being of program staff and offenders. The audit found a significant number of direct care staff positions were vacant; program staff worked a significant amount of overtime to provide safety, security, and treatment; and even with significant overtime, the program failed to meet its internal minimum staffing goals.

In April 2015, the second LPA performance audit report, "Larned State Hospital: Reviewing the Operations of the Sexual Predator Treatment Program, Part 2," considered how Kansas' SPTP compared to similar programs in other states and best practices, and what actions could be taken to reduce the number of offenders committed to the SPTP.

The audit found the Kansas program did not adhere to recommended practices for sexual predator programs to emphasize individualized treatment; residents completing the first five phases of the program were not necessarily equipped with the skills to be successful in finding a job or basic life skills; appropriate records and documentation to effectively manage the program were not maintained; and annual reports had not been filed as required by statute.

Additionally, the audit noted an insufficient local labor force will create staffing problems for the SPTP as it grows. The audit considered six options for reducing the resident population. Copies of the full audit reports and the highlights may be accessed at http://www.kslpa.org/.

Overtime All Funds Expenditures for the Kansas State Hospitals FY 2017 and FY 2018

	FY 2017		FY 2018
KNI	$ 183,719		$ 328,028
LSH	3,976,643		4,585,740
OSH	1,051,507		1,068,535
PSH	370,620		525,377

Staffing. Staffing shortages have persisted at LSH, resulting in an increase of overtime hours worked by existing staff. KDADS reported the hospital has struggled to recruit staff in a rural area with low unemployment. At the April 18, 2016, Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight (KanCare Oversight Committee) meeting, LSH employees discussed staffing problems at the facility. The testimony outlined how mandatory overtime and limited time between shifts were taking a toll on workers and their families. Those testifying spoke as individuals and not as representatives of KDADS or other state agencies (http://www.kslegislature.org/li_2016/b2015_16/committees/ctte_jt_robert_g_bob_bethell_joint_committee_1/documents/?date_choice=2016-04-18). Then-Interim Secretary Keck said staffing concerns at LSH were valid, and he had been working to improve employee morale since he took over in December 2015. In April 2017, Secretary Keck reported to the KanCare Oversight Committee staffing vacancies were decreasing and overtime was diminishing. However, in August 2018, Secretary Keck reported to the KanCare Oversight Committee that, despite efforts to improve staffing, recruitment and retention continues to be a problem at LSH.

In April 2016, about 60 mental health inmates were moved between state facilities as a means to alleviate staffing shortages at LSH. The plan moved dozens of inmates with mental health issues from LSH units to another facility

on the same campus run by the Department of Corrections. The inmates still received psychiatrist services in the new location. Concern was expressed by a Kansas Organization of State Employees representative that some inmates who need psychiatric care would be moved to facilities where corrections staff do not have mental health training.

Management. LSH also has faced management changes in recent years. The superintendent who had been at LSH since 2012 resigned in March 2016. The KDADS Commissioner of Behavioral Health Services served in an interim capacity until an interim superintendent was appointed in April 2016, while a search for a permanent superintendent took place. Bill Rein, former chief counsel for KDADS and most recently KDADS Commissioner of Behavioral Health Services, was named LSH Superintendent in June 2016. In August 2016, the LSH Chief Fiscal Officer (CFO) departed employment with the hospital. The CFO was facing a federal probe related to employment in a previous position. An audit of the hospital's finances was launched.

Additionally, the general counsel who led the legal department at LSH was transferred to the KDADS central office in Topeka in May 2016. A legal assistant position also was moved. KDADS said the move would allow the agency to use its legal staff more efficiently by having an employee previously focused on one state hospital assisting with other KDADS functions. Some OSH legal staff also were moved to the central office.

Parsons State Hospital and Training Center

PSH&TC is one of two residential treatment, training, and care facilities operated by the State of Kansas to serve individuals with intellectual and developmental disabilities whose circumstances require specialized residential service provisions. PSH&TC was originally opened in 1903 and primarily treats adult patients, though approximately 20 youth also receive treatment and reside at the facility.

In May 2018, an annual survey revealed PSH&TC was out of compliance with guidelines on facility staffing for physical therapy. In July 2018, a complaint survey was conducted, and the hospital was cited for issues with treatment of a patient and was placed in immediate jeopardy. The hospital was informed it must submit an acceptable plan of correction, or a recommendation would be made that its Medicare contract be terminated, which would prohibit the hospital from receiving Medicaid or Medicare reimbursements for patient care. PSH&TC submitted plans of correction for both surveys and was informed in October 2018 that the plans had been accepted, and the hospital was no longer in immediate jeopardy of losing federal funding.

Recent Legislative Action

Several bills were considered during the 2017 and 2018 Legislative Sessions.

2017 Policy

Senate Sub. for HB 2278 was passed by the 2017 Legislature and exempted the state hospitals and other select entities from a general requirement in law that public buildings have adequate security measures in place before the concealed carry of handguns could be prohibited.

Senate Sub. for HB 2002 was enacted in 2017 and authorized a Mental Health Task Force to meet in the fall of 2017 to study certain topics related to the current status of various mental health programs in Kansas and to provide recommendations to the 2018 Legislature. The Mental Health Task Force was facilitated by the Kansas Health Institute and a report was provided to the 2018 Legislature.

2017 Fiscal

The 2017 Legislature approved $11.8 million in FY 2017 and $6.6 million for FY 2018 as additional operating funding for OSH, primarily because the hospital lost federal funding as a result of decertification. The Legislature also added $4.7 million for both FY 2018 and FY 2019 to open at

least 20 additional beds for patients at OSH or in the community. The Legislature added language requiring KDADS to complete an engineering survey on the buildings at OSH to determine which buildings could be renovated and which buildings should be demolished, and the costs associated with both options. The Legislature also required KDADS to issue a request for proposal (RFP) for the construction of a 100-bed psychiatric care facility at OSH.

The 2017 Legislature added $6.5 million in FY 2017, FY 2018, and FY 2019 for LSH to replace federal and other funding lost due to a decrease in the number of patients eligible for Medicaid and Medicare reimbursements and cost recoupment by CMS due to reconciliation of past patient categorizations.

2018 Policy

In 2018, House Sub. for SB 109 was enacted reauthorizing the Mental Health Task Force to meet in the fall of 2018 to study the Kansas mental health delivery system and develop a strategic plan addressing the recommendations of the January 8, 2018, Mental Health Task Force report, including ascertaining the location and total number of psychiatric beds needed to most effectively deliver mental health services in Kansas. The Mental Health Task Force is currently meeting over the 2018 Interim.

2018 Fiscal

The 2018 Legislature added $8.2 million in FY 2018 and $16.1 million for FY 2019 for additional operating expenditures at OSH. The Legislature added $2.5 million in FY 2018 and $4.2 million for FY 2019 for LSH for expansion of the SPTP. Also, the Legislature added $559,765 for PSH&TC for FY 2019 to provide funding for 12.0 additional support staff positions as a result of the facility experiencing an increased number of patients requiring one-to-one or two-to-one care for extended periods of time.

State Hospital Financing

The state hospitals are primarily funded through three basic sources. The first is the State General Fund, which consists of money collected through various statewide taxes. The second is each hospital's fee fund, which includes collections from Medicare, private payments, Social Security, and insurance. The third source is federal Title XIX funding, also known as Medicaid. The federal Title XIX funding is transferred to the KDADS central pool and is redistributed among the four state hospitals in amounts equal to its approved appropriations.

State developmental disabilities hospitals (KNI and PSH&TC) are Medicaid certified as intermediate care facilities for persons with developmental disabilities, and nearly all of the people living in the facilities are covered by Medicaid. The state developmental disabilities hospitals submit annual cost reports that establish per diem rates they charge to Medicaid for each day a person covered by Medicaid lives in the facility.

The state mental health hospitals (LSH and OSH) establish per diem rates in much the same way as the state developmental disabilities hospitals, but are classified as institutions for mental disease. Due to federal rules, most state mental health hospital patients are not eligible for standard Medicaid match, but these hospitals are eligible for Medicaid payments through the DSH program. This program assists all acute care hospitals that serve a disproportionately high number of indigent persons. Kansas is currently pursuing a waiver to the federal rule prohibiting a Medicaid match for institutions for mental disease. In addition, Congress is currently considering changes to federal laws that may allow funding for short periods in cases where a mental impairment is combined with a opioid use disorder.

For more information, please contact:

David Fye, Principal Fiscal Analyst
David.Fye@klrd.ks.gov

Erica Haas, Principal Research Analyst
Erica.Haas@klrd.ks.gov

Iraida Orr, Principal Research Analyst
Iraida.Orr@klrd.ks.gov

Kansas Legislative Research Department
300 SW 10th Ave., Room 68-West, Statehouse
Topeka, KS 66612
Phone: (785) 296-3181